



AMT STATE SOCIETY MAILING LIST REQUEST FORM

TYPE OF LIST REQUESTED

1. Specify Certification Type (active members only):

\_\_\_ All Certification Types

\_\_\_ Medical Technologists

\_\_\_ Medical Laboratory Technicians

\_\_\_ Phlebotomy Technicians

\_\_\_ Office Lab Technicians

\_\_\_ Lab Consultants

\_\_\_ Medical Assistant

\_\_\_ Medical Administrative Specialists

\_\_\_ Allied Health Instructors

\_\_\_ Dental Assistants

2. Specify State(s):

\_\_\_\_\_

3. Requests for other lists:

\_\_\_ New Members Only (specify date joined range) From: \_\_\_\_\_ To: \_\_\_\_\_

\_\_\_ AMT Board, AMT Council, Publication and State Society Editors

OUTPUT

Please choose one of the following:

\_\_\_ Emailed File: Printer-ready format (Adobe PDF with label size in 1"x 2.63" - 30 labels/sheet)\*

\_\_\_ Emailed File: Text delimited\*

\_\_\_ Printed labels

\_\_\_ Paper copy (list)

Date Needed: \_\_\_\_\_

Contact: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

Other comments:

\_\_\_\_\_

\_\_\_\_\_

\* Note: File format attached.

**Columns**

<u>Name</u>	<u>Type</u>	<u>Size</u>
MemberID	Number (Long)	4
DateJoined	Date/Time	8
ExpirationDate	Date/Time	8
MemberClass	Number (Integer)	2
FirstName	Text	30
MiddleInitial	Text	20
LastName	Text	30
Suffix	Text	20
Company	Text	50
Addr1	Text	255
Addr2	Text	255
City	Text	255
State	Text	255
Zip	Text	255
Country	Text	255