



Atlanta Metro Celiacs - Membership Application

The Atlanta Metro Celiacs support group is managed by a volunteer board of directors and is a branch of the Gluten Intolerance Group of North America (GIG). Membership in the group is open to all individuals who are following the gluten-free diet. The group is based in Atlanta, and serving the Southeast region. The primary objective of the group is to offer support and information for those who are following the gluten-free diet and their family members/significant others. Please visit the group's website at www.atlantametroceliacs.org for additional information.

Funding for the group comes from membership dues and some charitable corporate donations. Membership dues are used to support/fund the activities and expenses of the group, such as, facility and speaker fees, meeting expenses, membership directory production, medical community outreach, support group materials and other costs directly related to ongoing support of the group. Some examples of membership benefits are shown below:

- **Welcome Letter** is a 10 page document full of information to help you follow the gluten free diet
- **Meeting notices** and communication regarding gluten-free issues (local and national) via email
- **Bi-monthly newsletter** filled with information on gluten free reading, vendors, events, recipes, etc.
 - Holiday themed mini-newsletters (Valentine's Day, Halloween, Thanksgiving, and Christmas)
- **Gluten Free Restaurant list** of more than 90 local restaurants with a gluten free menu and a **listing of Bakeries, Caterers and Chefs** who prepare/offer gluten free food/services

The membership year runs from January 1st through December 31st and is prorated for members who join after October 1st. To join, please fill out the form (only one per household), enclose a \$15 membership fee and mail it to:

Lori Pocock
c/o Atlanta Metro Celiacs
112 Wynfield Trace
Norcross, GA 30092

Family Name _____

Please list the Celiacs in the family _____

Address _____

City _____ State _____ Zip Code _____

Email address _____ Phone number _____

If you would like to recommend your doctor, please provide the following:

Type of Doctor:

- | | | |
|---|---|------------------------------------|
| <input type="checkbox"/> Primary Care Physician/Internal Medicine | <input type="checkbox"/> Dermatologist | <input type="checkbox"/> Dietician |
| <input type="checkbox"/> Gastroenterologist | <input type="checkbox"/> Pediatric Gastroenterologist | |

Physician's Name _____ Website _____

Address _____ City _____

State _____ Zip Code _____ Phone number _____