

**Grady Health System
Adopt-A-Unit
Registration Form
E-mail to beldridge@gmh.edu
Fax to 404-616-6856**

Name of Group: _____

Organizational Affiliation (if applicable): _____

Contact Person: _____

Address: _____

City: _____ **State:** _____ **ZIP Code:** _____

E-mail Address: _____

Phone: _____

Group's Mission: _____

Number in Group : _____

Special Interests: _____

Time Commitment: **Monthly** **Quarterly**

Preferred Day and Time to Visit: _____

DO NOT WRITE BELOW THIS LINE

FOR OFFICE USE ONLY:

Assigned Area: _____

Clinical Manager's Name: _____ **Phone:** _____

Beginning Date: _____