

MEMBERSHIP APPLICATION/DONATION FORM

APPLICANT INFORMATION

Name:		
Current address:		
City:	State:	ZIP Code:
Email:	Phone:	

SPOUSE INFORMATION IF JOINT MEMBERSHIP

Name:	
Email:	Phone:

MEMBERSHIP FEES

<input type="radio"/> 1 Year \$20	<input type="radio"/> 2 Years \$40
<input type="radio"/> 3 Years \$60	<input type="radio"/> 4 Years \$80

DONATIONS

<input type="radio"/> Donations \$	
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PAYMENT METHOD

<input type="radio"/> Cash	
<input type="radio"/> Check	
<input type="radio"/> Other	

SIGNATURES

I authorize the verification of the information provided on this form.

Signature of applicant/donor:	Date:
Signature of spouse <i>(only if for a joint membership)</i> :	Date:

Application may be mailed to: ELSWF
 Attention Membership Committee
 P O Box 426
 Pittsburg, Texas 75686

*please enclose applicable fee.
 *all donations are tax deductible

Thank You for your Support!

