WOODBURN AMBULANCE MEMBERSHIP APPLICATION

Name:____

Date of Birth:____

Street Address:____

City:____

State:_______________________________

Zip:________________________________

Mailing Address:____

City:____

State:_______________________________

Zip:________________________________

Phone Number:____

Email Address:____

Names of Spouse and legal dependents (under 26 years of age):

Last	First	Date of birth

Last	First	Date of birth
Last	First	Date of birth
Last	First	Date of birth

Payment type ($69/year per household):

[ ] Check enclosed – Amount $__________

[ ] Credit/Debit Card – Amount $__________

[ ] Please call me to get credit/debit card information over the phone upon receipt of this application

Card Type (circle one) Visa Mastercard Discover

Card# ___________________________________

Expires:__________________________________

CVV #____________________________________

Name on Card:____

Cardholder's Address:____

Zip:__________________

Signature of cardholder:____

***PLEASE MAIL THIS COMPLETED APPLICATION TO:

Woodburn Ambulance Membership Program

P.O. 584

Woodburn, OR 97071