
Last First Date of birth

Last First Date of birth

Last First Date of birth

Payment type (\$59/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