## 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):	

First

Last

Date of birth

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:	<del></del>		
CVV #			
Name on Card:			
Cardholder's Address:			
Zip:			
Signature of cardholder:			
***PLEASE MAIL THIS COME	PLETED APPLICATION TO:		
Woodburn Ambulance Mem	bership Program		
P.O. 584			
Woodburn, OR 97071			