

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
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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