



PO Box 523 Mamaroneck, NY 10543

# Membership Application

Date \_\_\_\_\_

Please Check One:  Individual  Household  Associate Individual  Associate Household

## 1<sup>st</sup> Member

Date of Birth \_\_\_\_\_

Name \_\_\_\_\_  
Last First MI

Street Address \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Local Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Local Emergency Contact Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

2<sup>nd</sup> Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_

2<sup>nd</sup> Emergency Contact Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Use Cane  Use Walker  Vision Impaired  Hearing Impaired  Have an Aide? Part-time  Full-Time

## 2<sup>nd</sup> Member (If Applicable)

Date of Birth \_\_\_\_\_

Name \_\_\_\_\_  
Last First MI

E-Mail Address \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Local Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Local Emergency Contact Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

2<sup>nd</sup> Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_

2<sup>nd</sup> Emergency Contact Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Use Cane  Use Walker  Vision Impaired  Hearing Impaired  Have an Aide? Part-time  Full-Time