



LAKE STEVENS SENIOR CENTER

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Lake Stevens, WA 98258

(425) 335-0345

info@LakeStevensSeniorCenter.com

OFFICE USE ONLY

Date: _____ Amt. Paid: _____

Cash Check # _____ By: _____

Membership Number(s):

#1 _____ #2 _____

2020 MEMBERSHIP FORM

Memberships are valid from January 1 to December 31 of each year. Dues are \$20 per person. To become a member (or to renew) please complete this form and return it, together with a check or cash for your dues, to the Center office. Thank you!

MEMBER #1			Age (check one)
NAME: _____			<input type="checkbox"/> Over 55
			<input type="checkbox"/> Under 55
MAIL ADDRESS: _____			
Street	City/State	Zip Code	
PHONE(S): _____		EMAIL: _____	
DO YOU LIVE: (Check One)	<input type="checkbox"/> Within the city limits of Lake Stevens? <input type="checkbox"/> Outside Lake Stevens city limits but in Snohomish County? <input type="checkbox"/> Outside Snohomish County?	Do you want a Membership Card? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Emergency Contact: _____		Relationship: _____	Phone: _____
<small>(Below this line is optional safety info; fill out at your discretion)</small>			
Doctor Name: _____		City: _____	Phone: _____
Medical Conditions: _____			
Allergic Reactions To: _____			
Daily Medications: _____			

MEMBER #2			Age (check one)
NAME: _____			<input type="checkbox"/> Over 55
			<input type="checkbox"/> Under 55
PHONE(S): _____ EMAIL: _____			
DO YOU LIVE: (Check One)	<input type="checkbox"/> Within the city limits of Lake Stevens? <input type="checkbox"/> Outside Lake Stevens city limits but in Snohomish County? <input type="checkbox"/> Outside Snohomish County?	Do you want a Membership Card? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Emergency Contact: _____		Relationship: _____	Phone: _____
<small>(Below this line is optional safety info; fill out at your discretion)</small>			
Doctor Name: _____		City: _____	Phone: _____
Medical Conditions: _____			
Allergic Reactions To: _____			
Daily Medications: _____			

I agree to abide by the Senior Center Policies and Procedures.

Signature: _____ **Date:** _____