

**MEMBERSHIP**  
**CHANGE**  
**FORM**



**\*Please complete applicable sections of this form to update your file.**

**LAST NAME:** \_\_\_\_\_ **MIDDLE:** \_\_\_\_\_ **FIRST:** \_\_\_\_\_

**CHANGE IN CLINIC:**

**Clinic Name:** \_\_\_\_\_ **Telephone:** ( ) \_\_\_\_\_

**Address:** \_\_\_\_\_ **Clinic Fax:** ( ) \_\_\_\_\_

\_\_\_\_\_ **County:** \_\_\_\_\_

\_\_\_\_\_ **Clinic Email:** \_\_\_\_\_

**Manager:** \_\_\_\_\_

**CHANGE IN HOME ADDRESS:**

**Home Address:** \_\_\_\_\_ **Telephone:** ( ) \_\_\_\_\_

\_\_\_\_\_ **Mobile Phone:** ( ) \_\_\_\_\_

**Home Email:** \_\_\_\_\_ **County:** \_\_\_\_\_

**Preferred Mailing Address:** ( ) Home ( ) Clinic **Preferred E-mail Address:** ( ) Home ( ) Clinic

**CHANGE IN MARITAL STATUS:**

**Applicant's New Name through Marriage:** \_\_\_\_\_

**Spouse's Full Name (if applicable):** \_\_\_\_\_

( ) Divorced ( ) Widowed

**CHANGE IN EMPLOYMENT STATUS:**

**Current Work Status:** ( ) Full Time ( ) Part-Time ( ) Retired ( ) Disabled

( ) On Military Leave ( ) Other: \_\_\_\_\_

**Average hours worked per week:** \_\_\_\_\_

**\*Please note: You may be eligible for reduced membership dues. Contact the office to inquire.**

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_