

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:** _____