



506 Fourth Street
Snohomish, WA 98291
360-568-0934

Membership Registration

\$40 Annual Dues per Person

\$130 Annual Dues per Business

Checks payable to: Snohomish Seniors

PLEASE PRINT CLEARLY

Last Name: _____ First Name: _____

Preferred Name: _____ Gender: _____ Birthdate: _____/_____/_____

Address: _____ City: _____ State: _____ Zip: _____

Phone (#1): _____ Phone (#2): _____

Email: _____

Would you like the monthly newsletter via **Email** or **US Mail**? (Please circle)

How did you hear about the Snohomish Senior Center? (Please circle): Facebook Tribune Event
Website Flyer Member (Name) _____ Other _____

Emergency Contacts/Medical Information

#1 Emergency Contact (Name): _____ (Relationship): _____

Phone (#1): _____ Phone (#2): _____

#2 Emergency Contact (Name): _____ (Relationship): _____

Phone (#1): _____ Phone (#2): _____

Doctor's Name: _____

Medical Clinic: _____ Phone: _____

Allergy Concerns: _____

Are there any medical conditions or physical limitations that SSC should be aware of?

Are you a Veteran? Yes/ No **Branch of Service:** _____

Any interests or abilities that you would like to share with our membership community? _____

For Office Use
Admin

Volunteer Interests (Please circle):

Kitchen/Lunch Receptionist Shuttle Driver Facility Monitor Gardening

Fabulously Frugal/Thrift Store Special Events Other? _____

For Office Use
Admin

I would like more information about (Please circle):

SSC Endowment Program (Legacy) Scholarship Request (For Members)

Gift Membership (For Members) SSC Golden Circle (Life Membership)

For Office Use
ED

I release the Snohomish Senior Center and all of its agents from any liability for any accident, injury or damages of any kind to persons or property that might occur while participating in Snohomish Senior Center activities. I grant the Snohomish Senior Center permission for the use of my image in photos or video for promotional materials.

In case of a medical emergency, I consent to treatment including First Aid, emergency transport and any procedures deemed necessary by medical personnel to safeguard my health.

Signature: _____ **Date:** _____

SNOHOMISH SENIOR CENTER WILL NOT SHARE OR RELEASE PERSONAL INFORMATION PROVIDED ON THIS FORM.

For Office Use Only Membership: General (50+) Associate (18-49) MSC By: _____

Date: _____ Receipt #: _____ Received by: _____ Expiration: _____
Cash/Credit/Check # _____

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Cash/Credit/Check # _____

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