SHOALHAVEN PHOTOGRAPHIC CLUB MEMBERSHIP FORM

2017 – 2018

NAME: _____

ADDRESS: _____

_____

HOME PHONE: _____ **MOBILE:** _____

EMAIL: _____

SPOUSE/PARTNER'S NAME: _____

MEMBERSHIP FEES: **12 months: $25** ☐ **6 months or less: $15** ☐

AMOUNT PAID: $_____ **I consent to receive emails and newsletters from the committee.**

Phone: ☐ **Email:** ☐

Cash ☐ **Cheque** ☐ **Direct Deposit** ☐

Signed: _____ **Date:** _____

Receipt Number (Office Use): _____