



SHOALHAVEN PHOTOGRAPHIC CLUB MEMBERSHIP FORM

2019 - 2020

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): _____