PLEASE PRINT CLEARLY

Name: ____

Address: ____

City: ______________________ St: _______ Zip: ________

Phone: ____________________ Cell: ___________________

Email: ____

Payment for: ____

CC Number: __ __ __ __ - __ __ __ __ - __ __ __ __ - __ __ __ __

Exp: _____/_____ CVS Code: ________Billing Zip____________

Card Type: Visa MasterCard American Express

Amount to charge card: ____________________

4% Processing Fee

Return this form along with a completed Membership Form to: Ksqha.4@gmail.com

Office Use Only

Received Date: ______________

Processed Date: _____________

Processed By: ________________________