COA MEMBERSHIP APPLICATION/RENEWAL FORM

INSTRUCTIONS: Please complete Section I, Section II, sign and date the Waiver of Responsibility/Consent for Release of Information and also indicate which Center/Satellite you attend. The membership fee per year for an individual is $15 and $20 for a couple. If mailing, please enclose a completed membership form and a check made payable to the CoA. If you would like a receipt mailed to you, enclose a self-addressed stamped envelope. If you are a **new member**, your membership card(s) will be mailed to the address you provide below.

Please circle which Center you attend and mail your completed form and payment to that Center.

Port Huron Senior Center 600 Grand River Avenue Port Huron, MI 48060	Washington Life Center 403 N. Mary Street Marine City, MI 48039	Yale Senior Center 3 First Street Yale, MI 48097	Conrad Community Center - Capac 585 N. Main Street Capac, MI 48014

SECTION I: Please print

Last Name: _____ **First Name:** _____ **Birthdate:** ____/____/____

Last Name: _____ **First Name:** _____ **Birthdate:** ____/____/____

Address: _____ **Apt. #** _____

City: _____ **Township:** _____ **State:** _____ **Zip Code:** _____

Phone Number: (____) _____ **Cell Phone Number:** (____) _____

Do you wish to receive your newsletter via email only? **YES** **NO**

Email Address: (Please print) _____

SECTION II:

Emergency Contact: _____ **Phone Number:** _____ **Relationship:** _____

Emergency Contact: _____ **Phone Number:** _____ **Relationship:** _____

Waiver of Responsibility/Consent For Release of Information

The undersigned hereby agrees to hold harmless and indemnify the Council on Aging, Inc., serving St. Clair County its agents and the Senior Center for any and all injuries that might occur in the preparation and performance of any volunteer services, activities and/or programs. I understand that services, activities and/or programs may take place at the homes of senior citizens, at the senior center, at satellite centers, or other arranged venues. The undersigned understands that in certain situations a medical release from the physician may be required regarding their ability to participate in a program/activity before participation is allowed.

The undersigned hereby gives consent for the use of their name, comments, photograph, and/or video image for the promotion of the Council on Aging's programs and services through displays, newspaper articles, brochures, videotapes and computer media. The use of their appearance by the Council on Aging, Inc., serving St. Clair County will not violate the rights to any person or organization and will not incur any liability for payment to any person or organization.

Signature	Date	Membership Number
Signature	Date	Membership Number

Center or Satellite you attend: _____

FOR OFFICE USE ONLY: Membership Number:	Expiration Date:	Date Processed:
Membership Number:	Expiration Date:	Date Processed:
Amount Received:	Receipt Number:	Processor's Initials: