



WFAPA Membership Form

Name: _____ Spouse/Significant Other: _____

Address: _____ City: _____

State: _____ Zip: _____ Fax Number: _____

Phone Number: _____ Email: _____

County, State or Agency Name (that licenses you): _____

Membership Classification: Adoptive Parent(s) Foster Parent(s) Kinship Parent(s)
 Agency Community Supporter

Would you be willing to help out with WFAPA? Yes No

Additional Donation: \$5 \$10 \$25 \$50 Other _____

GO GREEN! I'd like to "go green" and paperless by receiving my newsletter online only.

Membership dues ~ \$10.00 Per Adult

Total Amount Enclosed \$ _____

Cash: _____ Check #: _____ Credit Card: MasterCard Visa American Express Discover

Credit Card #: _____ Name On Card: _____

Expiration Date: _____ CVV: _____ (3 Digit # On Back Of Your Card) Zip Code: _____

Applicant Signature: _____ Date: _____