Affiliate/Individual Membership Application

Member Information Form

About You: Complete this section in its entirety. **Please PRINT clearly**

Name: ____________________

Address: ____________________ **County:** ____________

City: ____________________ **State:** ________ **Postal Code:** ____________

Business Phone: (   ) ____________ **Cell Phone:** (   ) ____________

Email Address: ____________________

Web Address: ____________________

Agency Affiliation: ____________________

Who is the Senator who serves your area? ____________________

Who are the House of Representative members in your area? ____________________

____________________ ____________________

ARTICLE III - MEMBERSHIP Section **Membership Criteria.**

Eligibility for membership shall be approved by a majority vote of the Board of Directors and shall not be denied for reason of race, color, religion, sex, age or national origin. Membership will be open to any company or individual meeting the criteria established in Section 2 herein, and willing to abide by the by-laws of the Association.

Section 2 C. Affiliate Membership. Any company or individual that has an interest in the purposes of the SOUTH DAKOTA AMBULANCE ASSOCIATION, but shall not include those eligible for Active or Associate or Corporate Membership. Affiliate members shall have no voting rights, shall not hold office or serve on the Board of Directors.

APPENDIX A: Dues Structure

Affiliate Membership: $ 25.00 per Individual ☐

Completed Application can be mailed to:

SD Ambulance Association
PO Box 543
Spearfish, SD 57783

Administration Use Only:

Date Paid: ____________ ***Amt Paid:*** ____________
Check #: