



MEMBERSHIP ENROLLMENT

Carroll County Community Center

FOR OFFICE USE:

MEMBER # _____ DATE _____

TYPE OF MEMBERSHIP:

- Family
 Adult
 College
 SP Family
 Senior
 Youth
 Scholarship Discount
 Military Discount
 Partnership Discount

First Name	Last Name	Occupation		
Address	City	Zip		
Home Phone	Cell Phone	Work Phone		
Email Address	Date of Birth			
<i>Complete the following for Family Memberships Only</i>				
First Name	Last Name (if different)	Gender	Date of Birth	School or Occupation
Spouse		<input type="checkbox"/> Male <input type="checkbox"/> Female		
Dependent Child #1		<input type="checkbox"/> Male <input type="checkbox"/> Female		
Dependent Child #2		<input type="checkbox"/> Male <input type="checkbox"/> Female		
Dependent Child #3		<input type="checkbox"/> Male <input type="checkbox"/> Female		
Dependent Child #4		<input type="checkbox"/> Male <input type="checkbox"/> Female		
Dependent Child #5		<input type="checkbox"/> Male <input type="checkbox"/> Female		

In case of an emergency contact: _____ **Phone #** _____

I hereby release any and all rights and claims for injuries and damages I may have against the Carroll County Community Center, the Board of Directors and staff. By applying for membership, I understand that my name and the names of my family members listed on this application will be cross-referenced with the Indiana Sex & Violent Offender Registry, and that my application for membership will not be considered if my name appears on the Registry.

Signature: _____ **Date:** ____/____/____ (registry checked)

MEMBERSHIPS ARE NOT REFUNDABLE

For Office Use:

Staff Initials: _____ Date Received: _____ Membership Director Initials: _____ Date Entered _____