

Date: \_\_\_\_\_

## GHNPS Member Form July 2017 - June 2018

The PEAK Center

Encore Experiences

<input type="checkbox"/> <b>Basic Member</b> - \$25.00 Individual / \$35.00 Couple (Includes: Newsletter Pick Up - \$5.00 Class Fee - Free Coupons)
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<input type="checkbox"/> <b>Supporting Member</b> - \$35.00 Individual / \$50.00 Couple (Includes: Newsletter Mailing, Tote Bag, \$3.00 Class Fee, 6 Week class series coupon, Free Coupons, member only events)
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<input type="checkbox"/> <b>Life Long Member</b> - \$250.00 Individual / \$450.00 Couple (Includes: Newsletter Mailing, Tote Bag, \$3.00 Class Fee, 6 Week class series coupons, Free Coupons, Members only events, plus VIP & Pillar special events)
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**First Name:** \_\_\_\_\_ **Middle Initial:** \_\_\_\_\_

**Last Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_

**City/State/Zip:** \_\_\_\_\_

**County:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Social Security #:** Last Four Digits XXX-XX-\_\_\_\_-\_\_\_\_ **\*\*Required\*\***

<b>Ethnicity:</b> <input type="checkbox"/> Hispanic <input type="checkbox"/> Non- Hispanic
<b>Race:</b> <input type="checkbox"/> American Indian/ Native Alaskan <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Non-Minority (White, Non Hispanic) <input type="checkbox"/> Asian <input type="checkbox"/> White- Hispanic <input type="checkbox"/> Other

**Marital Status**  Married  Widowed  Divorced  Single

**Gender:**  Male  Female **Veteran:** Yes / No

<b>Household Income:</b> _____
1 Person Household: <input type="checkbox"/> <b>Less than \$12,100</b> <input type="checkbox"/> \$12,100 - \$33,499 <input type="checkbox"/> \$33,500 and greater
2 Person Household: <input type="checkbox"/> <b>Less than \$16,500</b> <input type="checkbox"/> \$16,501 - \$39,500 <input type="checkbox"/> \$39,501 and greater

**Emergency Contact:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_  
**Emergency Telephone Numbers:** Home: \_\_\_\_\_ Cell: \_\_\_\_\_

**Allergies/Emergency Medical Conditions:** \_\_\_\_\_