



Partner Membership Application Form

Instructions

Date: _____

Please print or type. Submit this application form with your \$100 annual dues directly to:

NEAFCS Partner Membership
140 Island Way
Suite 316
Clearwater Beach, FL 33767

First Name			Middle Name			Last Name		
Job Title				Employer				
Work Mailing Address			City		State/Territory		Zip	
Work Physical Address (if different from work mailing address)			City		State/Territory		Zip	
Home Address			City		State/Territory		Zip	
Work Email Address				Home Email Address				
Work Phone/Extension			Work Fax			Home Phone		

Send mail / e-mail to my (check one): Work Address Home Address

Please check the ONE box that BEST describes your **RELATIONSHIP TO NEAFCS PROGRAMMING**:

- | | | | |
|---|--|--|---------------------------------|
| <input type="checkbox"/> Nutrition | <input type="checkbox"/> Parenting Education | <input type="checkbox"/> Community Development | <input type="checkbox"/> Aging |
| <input type="checkbox"/> Food Safety | <input type="checkbox"/> Child Development | <input type="checkbox"/> Administration | <input type="checkbox"/> Health |
| <input type="checkbox"/> Financial Management | <input type="checkbox"/> Housing | <input type="checkbox"/> 4-H Youth Development | |
| <input type="checkbox"/> Human Development | <input type="checkbox"/> Clothing/Textiles | <input type="checkbox"/> Other: _____ | |

Send your completed form directly to:
140 Island Way, Suite 316, Clearwater Beach, FL 33767