



ANNUAL DUES ARE \$ 35.00
 Make checks payable to SHOPMOM.
 Mail this form and check to:

 JENNIFER ILCONICH
 146 VALLEYCREST DR.
 CECIL, PA 15321

 Or turn in at the General Meeting

MEMBERSHIP FORM

MEMBER INFORMATION

FIRST NAME _____ LAST NAME _____
 HOME PHONE _____ MOBILE PHONE _____
 ADDRESS _____ BIRTHDATE ____/____/____
 CITY _____ STATE _____ ZIP CODE _____
 EMAIL _____
 OCCUPATION _____ COMPANY _____
 WORK PHONE _____ WORK EMAIL _____
 SPOUSE'S NAME _____ SPOUSE'S OCCUPATION _____
 SPOUSE'S COMPANY _____

REFERENCE

OB/GYN _____ OB PHONE _____
 OB ADDRESS _____
 CITY _____ STATE _____ ZIPCODE _____
 We will send your OB/GYN club information unless you circle No..... NO

PEDIATRICIAN _____ PED. PHONE _____
 PED. ADDRESS _____
 CITY _____ STATE _____ ZIPCODE _____
 We will send your Pediatrician club information unless you circle No..... NO

CHILDREN

SEX OF TWINS (Circle) M/M M/F F/F BIRTHDAY ____/____/____ TYPE (circle) - FRATERNAL OR IDENTICAL
 TWIN "A" NAME _____ TWIN "B" NAME _____

DO YOU HAVE HIGHER ORDER MULTIPLES? (Circle) YES NO
 PLEASE LIST ALL OTHER CHILDREN BELOW :

CHILD'S NAME _____ BIRTHDAY ____/____/____
 CHILD'S NAME _____ BIRTHDAY ____/____/____
 CHILD'S NAME _____ BIRTHDAY ____/____/____
 CHILD'S NAME _____ BIRTHDAY ____/____/____

You have my permission to include the above information in the Club directory, which will be distributed to SHOPMOM members only. I, the undersigned, understand that my participation and the participation of any members of my family in any SHOPMOM activity or program, is completely voluntary, and we hereby give permission for myself and my family to join in those activities or programs. My family shall hold SHOPMOM harmless as well as any Club volunteers or representatives, paid or unpaid, and/or the providers of any activity or program location and/or materials from any liability and/or responsibility for any accident, illness or injury that occurs during or as a result of any function or program. I accept that the final responsibility for my safety and that of my family rests with me. All members must have Liability Release on file with SHOPMOM before attending any activities or programs.

Member Signature _____ Date ____/____/____

MEMBERSHIP USE ONLY
 Check # or Reference _____ Date Paid ____/____/____ Amount Paid \$ _____ Payment Logged: