



# MEMBERSHIP ENROLLMENT

# Carroll County Community Center

For Office Use Only

MEMBER # \_\_\_\_\_

DATE \_\_\_\_\_

TYPE OF MEMBERSHIP:

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

First Name	Last Name	
Address	City	Zip
Home Phone	Work Phone	Cell Phone
Email Address	Date of Birth	

*(Please complete the following for Family Memberships only)*

First Name	Last (if different)	Gender	Date of Birth	School
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**

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Date Received: \_\_\_\_\_ Staff's Initials: \_\_\_\_\_ Date Entered in Computer: \_\_\_\_\_ Membership Director's Initials: \_\_\_\_\_