



Membership Application

Name:	Business Phone:
Business Address:	Mobile Phone:
Occupation/Title:	Fax Number:
Employer:	Business Email:
Home Address:	Home Phone:
Preferred Address: <input type="checkbox"/> Home <input type="checkbox"/> Business	Home Email:
Membership(s) currently held – Describe responsibilities: <p style="text-align: right;">Attach additional page if needed.</p>	
Please explain why you are interested in joining The Shakers. <p style="text-align: right;">Attach additional page if needed.</p>	
Please describe what you believe you can contribute to The Shakers. <p style="text-align: right;">Attach additional page if needed.</p>	
Sponsor:	

Return form to:

Community Medical Foundation
P.O. Box 1232
Fresno, CA 93715
559-459-2670
Attention: The Shakers