Life Flight Individual/Family Membership Application

Member Information

Name:	
Birth Date:	Phone:
Mailing Address:	

Street or P.O. Box City State Zip

Family Members

First and last name	Relationship	Birth Date

Membership Period *(Mark with an X.)*

____ 12 months: $60 ____ 24 months: $115 ____ Five years: $250

Tax-deductible Donation

In addition to my fee, please use my contribution of $ ________ *(mark with an X)*

____ to support Life Flight ____ where most needed.

Payment Method *(Mark with an X.)*

____ Check enclosed *(Please make payable to Wyoming Medical Center Life Flight.)*

____ Visa ____ MasterCard ____ Discover ____ AMEX

Account Number:	3-Digit Security Code:
Expiration Date:	
Signature:	

Please fill out form and mail to: Wyoming Life Flight, 1233 E. Second St., Casper, WY 82601