



# CARROLL COUNTY COMMUNITY CENTER

*Physical, Mental, and Spiritual Health*

## MEMBERSHIP ENROLLMENT

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 <span style="float: right;">Zip</span>
Home Phone	Work Phone <span style="float: right;">Cell Phone</span>
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**

For Office Use Only:

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