

MEMBERSHIP INFORMATION FORM



WASHINGTON STATE RESIDENTIAL CARE COUNCIL (WSRCC)

Dues: 7/1/09 - 6/30/10 - \$300 per licensed home
Please fill out one application per home

Provider Contact Information

DSHS License #	Number of Beds:		
Provider Name	Spouse		
AFH Name			
AFH Mailing Address	City	Zip	County
Provider Address (If different)	City	Zip	County
Phone	Fax		
Email Address			
Website Address			
Signature	Date		

Enclosed is my check for membership in the amount of \$ _____ made payable to WSRCC

OR

Charge my membership in the amt of \$ _____ to: VISA Master Card American Express

Account #

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 Expiration Date ___/___

Security Code _____ (the last three numbers in or beside the signature panel on the back of your card)

Name as shown on the card _____

Signature _____ Date _____

You can now pay on line by visiting our Website @ www.wsrcc.org

For Office Use ONLY			
Check # _____	Check Date _____	Date Received _____	Amount \$ _____
Membership Year _____	Membership Number _____		
CC Auth Number _____	WSRCC Pd _____	Chapter Pd _____	Cert Sent _____

Mail this form with your payment to:
WSRCC Membership: 523 Pear Street S.E., Olympia, WA 98501
or send it by fax to: (360) 943-6653

Please visit our Website at www.wsrcc.org