

## MEMBERSHIP APPLICATION

New Member

Renewal

Fee Enclosed:     Professional \$20.00     Student \$10.00

NAME: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

JOB TITLE: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

\_\_\_\_\_

DAYTIME PHONE NUMBER: \_\_\_\_\_

FAX NUMBER: \_\_\_\_\_

EMAIL: \_\_\_\_\_

### Volunteer Opportunities

We want to use your talents in our organization. Would you be willing to:

Serve as a committee member

Contribute an article for the newsletter or journal

Other \_\_\_\_\_

### Your Professional Input

What kinds of training/continuing education would you like FSHA to provide: \_\_\_\_\_

\_\_\_\_\_

**Please send completed application and check payable to FSHA to:**

Florida School Health Association

c/o 64 Raintree Circle

Palm Coast, FL 32164