



{ Wellness Within Reach }

MEMBERSHIP APPLICATION INFORMATION - INDIVIDUAL AND FAMILY

Please fill out the following application and return by mail, fax or email to:

MAIL
WholisticARE
1200 NE 7th St
Grants Pass, OR 97526

FAX
WholisticARE
541.476.9763

EMAIL
Membership@WholisticARE.com

How did you hear about this membership program?

Radio Newspaper Sneak Preview Internet Other

Referred by a friend (please list as we would like to give them a free month of membership):

WholisticARE Employee

MEMBER INFORMATION (please print)

Member Name: Date of Birth:

Gender:

Address: City: State: Zip:

Phone: cell: home: Email:

Emergency Contact Name: Phone:

May we send you updates by email?

ADDITIONAL FAMILY MEMBERS

Member Name: Date of Birth:

Member Name: Date of Birth:

Member Name: Date of Birth:

Member Name: Date of Birth:

Member Name: Date of Birth:

I have read and understood the "Membership Agreement" included with this application for WholisticARE and agree to abide by all the terms and conditions listed herein.

Credit Card Information: Card Number:

Type: Visa Mastercard Expiration: Security:

Signature of authorized representative: Date: