

CAFA New Membership Application

Application Date: _____

For Official Use

Date Approved: _____

President's Signature: _____

Application Type: Single Membership
 Family Membership

Name: _____ DOB: _____ (MM/DD)

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____ Cell: (____) _____

Email Address: _____

Gender: Male Female Marital Status: Single Married

If Married, Spouse's Name: _____ DOB: _____ (MM/DD)

How long have you lived in Central Florida? _____

How many children live in your household? _____

Please Give One Referral

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Home Phone#: (____) _____ Cell: (____) _____

Indicate with a check mark the committee/s you would most likely be interested in serving on.

Building Education, Youth & Adult Finance & Planning
 Fund Raising/Entertainment Medical Membership/Sun Shine
 Newsletter Publication Public Relations

Membership Fees:

Single Membership: **\$35.00**

Family Membership: **\$45.00** (Couples with dependent children under 18 years living at the same address)

I agree to be governed by the **By-Laws** of the Organization

Signature: _____

Application & Fees Mailing Address
 Caribbean and Floridian Association, Inc.
 Attn: New Membership
 P.O. Box 450786
 Kissimmee, Florida 34743-0786