



<b>MEMBERSHIP APPLICATION</b>	
Name:	Date:
Address:	Phone #:
City, State, Zip:	Work #:
E-mail address:	Fax #:
<input type="checkbox"/> Single (\$10.00) <input type="checkbox"/> Family (\$15.00) <input type="checkbox"/> Medical Professional (\$25.00) <input type="checkbox"/> Patron (\$50.00) <input type="checkbox"/> Courtesy	<input type="checkbox"/> Other Donation (please list below)  _____
<input type="checkbox"/> Renewal <input type="checkbox"/> New	<input type="checkbox"/> I would like to become a volunteer

Please remit payment and completed form to:

**Lupus Foundation**  
**P.O. Box 139**  
**Utica, N.Y. 13503**

*We appreciate your support!*

For more information call:  
**315-829-4272**  
 or toll free  
**1-866-2-LUPUS-4**  
 e-mail - [lupusmidny@aol.com](mailto:lupusmidny@aol.com)  
[www.nolupus.org](http://www.nolupus.org)