The Pap Corps®
Champions for Cancer Research

NEW MEMBER FORM

Please return completed form to the Pap Membership Committee (Karen Zall and Dorothy Bernstein).

Date _____ Name (Ms./Mrs./Mr./Dr.) _____ Suffix _____

Spouse/Partner Name_____

Address _____

City _____ State_____ Zip Code _____

Email _____ Birth Month _____

If applicable: Seasonal Address _____

City _____ State _____Zip Code _____

Effective from _____ to _____

New Donor (Non-Member) Form

Date: _____ ( ) Individual ( ) Business

Title (Ms./Mrs./Mr./Dr.) Name _____ Suffix _____

Company _____

Address _____

City _____ State_____ Zip Code _____

Phone 1 _____ Phone 2 _____

Email _____ Relationship (self, spouse, foundation, etc.) _____

( ) Annual Membership: $40 ( ) Life Membership $300

( ) I am interested in volunteering