



MEMBERSHIP FORM

Name	
Address	
City, State, ZIP	
Home Phone	
Cell Phone	
Work Phone	
Place of Employment	<input type="checkbox"/> I Am Retired
Position/Title	
Preferred Email	
Alternate Email	
FBICA Year of Graduation	
FBICA Class Location	

\$75
New Membership
12 months

\$1,000
Lifetime Membership
Does not expire

Donation
Amount: \$ _____

Please initial below to acknowledge your interests.

- I would like to participate as an FBICLECAAA volunteer.
- I would like to share my contact information with my classmates.
- I would like to be acknowledged as an FBICLECAAA Alumni on the website and/or any other promotional materials.
- The FBICAF has my permission to use my photo in their publications in conjunction with the FBICLECAAA website and/or any other promotional materials.

Pay online at www.fbiclecaaa.org/join or mail your check and this form to:

FBICLECAAA

7 St. Clair Avenue
PMB 216
Cleveland, OH 44114

Payment Date: _____

Payment Method: _____