



MEMBERSHIP APPLICATION
Powell Community Center

All personal information is confidential and is not shared with other agencies.

Residency identification (current utility bill, pay stub, tax or bank statement) or business employment verification required at time of registration.

Applicant Name: _____ D.O.B. _____
(please print)

Address: _____ City/State/ZIP _____
(please print)

Phone (H): _____ Phone (W): _____

Phone (C): _____ Cellular Carrier: _____

Email: (required for Auto-Pay) _____ Key Fob # _____

Emergency Contact (REQUIRED):

Name: _____ Relation: _____ Contact #: _____

Name: _____ Relation: _____ Contact #: _____

Type of Membership: (please check box) Annual 6-Month

Mission Resident: Youth Adult Senior Household 2 Person Family

Mission Business: Youth Adult Senior Household 2 Person Family

Business Name: _____ Proof of Employment: _____

Non-Mission: Youth Adult Senior Household 2 Person Family

Additional Member Information: (additional members over 18 must provide proof of residency)

	Name	Key Fob #	Date of Birth
1.			
2.			
3.			
4.			

The undersigned, as a participant, parent/guardian or designee of the above named participants of the Mission Parks & Recreation department do understand that in consideration of the City of Mission, Kansas I (we) hereby release them, their officers, agents or employees from all liability demands or claims for loss, damage or injury resulting from participation in any activity sponsored by the Mission Parks & Recreation Department as no insurance is provided. I (we) recognize and understand that participation require that all participants be in good health. I (we) declare that all participants are in good health. If a participant is a minor, consent is given for participation in all activities and for any necessary first aid or medical treatment. By signing this document I (we) signify we have read all policies pertaining to participation and agree to abide by such policies. **I (we) understand memberships are offered on an annual or 6-Month term only.**

Signature: _____ Date: _____

Entry Desk eTrak Verification (please check):

<input type="checkbox"/>	Name	<input type="checkbox"/>	Email
<input type="checkbox"/>	DOB	<input type="checkbox"/>	Insurance Policy
<input type="checkbox"/>	Residency	<input type="checkbox"/>	Group/Create a Family
<input type="checkbox"/>	Phone	<input type="checkbox"/>	Emergency Contact
<input type="checkbox"/>	Carrier/Provider	<input type="checkbox"/>	Photo

\$ _____	\$ _____
Initial Membership Fee	Monthly Payment Fee
_____	_____
Start & Expiration Date	Staff Initials