



Date Purchased \_\_\_\_\_  
Membership Number \_\_\_\_\_

## CHILDREN'S MUSEUM OF THE SHOALS MEMBERSHIP FORM

- I wish to become a member of the Children's Museum of the Shoals!  
 I wish to renew my membership of the Children's Museum of the Shoals!  
 I wish to give a gift membership to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

E-Mail address: \_\_\_\_\_

The following people are included in the membership:

Spouse (if not included above): \_\_\_\_\_

Child's Name: \_\_\_\_\_ Child's Name: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Child's Name: \_\_\_\_\_

If a gift membership; purchased by: \_\_\_\_\_

Gift card to read: \_\_\_\_\_

### Membership Fees (Non-Transferable):

- Basic (up to 2 people) \$60.00  
 Family/ACM Reciprocal Membership (up to 6 people) \$125.00

### Contributing Memberships:

- |  |  |
|--|--|
| <input type="checkbox"/> Supporter \$150.00  | <input type="checkbox"/> Sponsor \$250.00  |
| <input type="checkbox"/> Benefactor \$500.00 | <input type="checkbox"/> Patron \$1,000.00 |

### Method of Payment: Cash, or

My check/money order payable to the Children's Museum of the Shoals for \$\_\_\_\_\_ is enclosed.

I wish to charge my membership to my  VISA or  MasterCard

Account# \_\_\_\_\_ Expiration Date: Mo. \_\_\_\_ Yr. \_\_\_\_

Signature as it appears on credit card:  
\_\_\_\_\_

Drop off, mail, or fax form and payment to:

Children's Museum of the Shoals, 2810 Darby Dr., Florence, AL 35630

256-765-0500

[www.shoalschildrensmuseum.org](http://www.shoalschildrensmuseum.org)

Fax: 256-764-7377

For office use only: POS \_\_\_\_\_ Data Base \_\_\_\_\_ TKU \_\_\_\_\_ ACM \_\_\_\_\_ ZIP \_\_\_\_\_ e-mail \_\_\_\_\_