Please Print Clearly.

Membership Fee $25.00

PAHA Member's Name _________________________________ _________________	**Membership # _______**	
Home Address	**Home Phone #**	
	Cell Phone #	
	TransHelp ID #	
Email Address:		
Emergency Contact	**Name:**	
	Relationship:	**Phone:**
Mobility Device(s) You Use *(Choose all that apply)*	Cane ___ Walker ___ Manual Wheelchair ___ Power Wheelchair ___ Scooter ___ Other Device ___________________________________	
Important Information and Medical Conditions		

Person Filling the form: ***Please Print Clearly***

___________________________ Name:

__________________________ Signature:

________________________ Date:

Thank you for filling this out and returning it to PAHA!