Membership Form

Membership Levels (choose one)

☐ Lifetime $500 - $999
☐ Single $25 - $49
☐ Health Professional $50 - $99
☐ Courtesy (financial need)
☐ Family $40 - $49

Member information

First Name:_____ Last Name:_____

Address Line 1 (street):_____

Address Line 2:_____

City:_____ State:_____ Zip:_____

Phone: (_____)_____

Email (To keep you updated only. We do not share member emails.):

_____

Payment *required information

☐ Check enclosed ☐ Credit card (credit card information is not kept on file)

☐ VISA ☐ MasterCard

* Cardholder's full name:_____
* Credit card number:_____
* Expiration date (mm/yyyy):_____ CVV (3-digit number on back of card):_____
* Billing information if different than information above:

Address Line 1 (street):_____

Address Line 2:_____

City:_____ State:_____ Zip:_____

Thank you for your membership. Please mail this form with payment to:

Lupus Foundation of Florida
535 Central Avenue, Suite 304
St. Petersburg, FL 33701