PHYSICAL THERAPY ALUMNI ASSOCIATION MEMBERSHIP FORM

PERSONAL INFORMATION
Name:______________________________ Maiden Name:________________ Degree:__________ Year:_____

Street:____________________________________________________________________________________

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Email Address: ____________________________________________

MEMBERSHIP

$______ Member
□ Student – $10  □ New Professionals (within 1st three years of graduation) – $25
□ Professional (beyond 3rd year of graduation)– $40  □ Lifetime – $250

$______ Donation (Optional)

$______ TOTAL PAYMENT

PAYMENT OPTIONS

_____ Check enclosed (Please make checks payable to the UC Denver Alumni Relations)

_____ Please charge my credit card:  □ VISA  □ MASTERCARD  □ AMERICAN EXPRESS

Card Number:________________________________________ Expiration:____ /____

Signature:________________________________________

Please mail or fax this form with payment to:  University of Colorado Denver
Office of Alumni Relations
13001 E. 17th Place, A080
PO Box 6508
Aurora, Colorado  80045

If you have questions, please contact our office at:  1.877.HSC.ALUM or 303.724.2518 (office) 303.724.1521 (fax)
healthalumni@ucdenver.edu

FOR OFFICE USE ONLY:  EID # _____________  PROCESSED DATE _____________