



**SOUTH CAROLINA
EMERGENCY MEDICAL SERVICE ASSOCIATION**

**First Responder Agency
Associate Membership Fee Invoice**

(This individual membership is for a period of one year from the date on this application.)

First Responder Agency- \$500.00

Name: _____ **Phone:** _____

Organization: _____ **Fax:** _____

Address: _____ **Email:** _____

City: _____ **State** _____ **Zip** _____

Please submit to: South Carolina EMS Association
P.O. Box 378
Lexington, SC 29071