SOUTH CAROLINA
EMERGENCY MEDICAL SERVICE ASSOCIATION

MEMBERSHIP APPLICATION

(Please print application)

TYPES OF MEMBERSHIP:

SERVICE:

_______Number of Licensed Ambulance(s) X $100.00

Date: ____________

Total fees submitted: _________

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

Name:_____________________________ Phone:_____________________

Organization:_______________________ Fax:_______________________

Address:___________________________ Email:_____________________

City:____________________State______Zip__________

Please return application and membership dues to:

South Carolina EMS Association
P.O. Box 378
Lexington, SC 29071