



**SOUTH CAROLINA  
EMERGENCY MEDICAL SERVICE ASSOCIATION**

**MEMBERSHIP APPLICATION**

(Please print application)

**TYPES OF MEMBERSHIP:**

\_\_\_\_\_ **Vendor: \$500.00**

\_\_\_\_\_ **Corporate/Associate: \$500.00**

**Date:** \_\_\_\_\_

**Total fees submitted:** \_\_\_\_\_

\_\_\_\_\_  
(This vendor 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