EMPIRE Mental Health Support

# MEMBERSHIP FORM

Name: _____

Address: _____

City: _____

State/Zip: _____

Phone: _____

Email: _____

Check all that apply:

☐ $5 Individual membership

☐ I also want to donate $ _____, in honor/ memory of _____

_____

Date: _____

Mail completed form with a check to:

Empire Mental Health Support
PO Box 88631
Sioux Falls, SD 57109

*Thank you for your support!*

Rev. 3-1-2024