



# MEMBERSHIP APPLICATION

SYLVESTER POWELL, JR. COMMUNITY CENTER  
6200 Martway • Mission, Kansas 66202  
913-722-8200 • www.missionks.org



All Personal information is confidential and is not shared with other agencies. **Residency identification (current utility bill, pay stub, tax or bank statement) or business employment verification required at time of registration.**

APPLICANT NAME \_\_\_\_\_ D.O.B. \_\_\_\_\_  
PLEASE PRINT

ADDRESS \_\_\_\_\_ CITY/STATE/ZIP \_\_\_\_\_  
PLEASE PRINT PLEASE PRINT

PHONE (H) \_\_\_\_\_ PHONE (W) \_\_\_\_\_

PHONE (C) \_\_\_\_\_ CELL PHONE PROVIDER \_\_\_\_\_

EMAIL *(required for Auto-Pay)* \_\_\_\_\_ Primary Master Pass #: \_\_\_\_\_

**EMERGENCY CONTACT:**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Contact #: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Contact #: \_\_\_\_\_

**TYPE OF MEMBERSHIP:** *(please check box)*       ANNUAL       6-MONTH       PREMIUM

**Mission Resident:**     Youth     Adult     Senior     Senior Couple     Family

**Mission Business:**     Youth     Adult     Senior     Senior Couple     Family

**Business Name:** \_\_\_\_\_ **Proof of Employment?** \_\_\_\_\_

**Non-Mission:**       Youth     Adult     Senior     Senior Couple     Family

### ADDITIONAL MEMBER INFORMATION:

_____	_____	_____	_____	_____	_____
Name	Master Pass #	Date of Birth	Name	Master Pass #	Date of Birth
_____	_____	_____	_____	_____	_____
Name	Master Pass #	Date of Birth	Name	Master Pass #	Date of Birth
_____	_____	_____	_____	_____	_____
Name	Master Pass #	Date of Birth	Name	Master Pass #	Date of Birth

The undersigned, as a participant, parent/guardian or designee of the above named participants of the Mission Parks & Recreation Department do understand that in consideration of the City of Mission, Kansas I (we) hereby release them, their officers, agents or employees from all liability demands or claims for loss, damage or injury resulting from participation in any activity sponsored by the Mission Parks & Recreation Department as no insurance is provided. I (we) recognize and understand that participation require that all participants be in good health. I (we) declare that all participants are in good health. If a participant is a minor, consent is given for participation in all activities and for any necessary first aid or medical treatment. By signing this document I (we) signify we have read all policies pertaining to participation and agree to abide by such policies. **I (we) understand memberships are offered on an annual, 6-month only.**

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

OFFICE USE: \$ \_\_\_\_\_ Paid in Full Membership Fee      \$ \_\_\_\_\_ Bank Draft Membership Fee      **Circle One**

\_\_\_\_\_ Start & Expiration Dates      \$ \_\_\_\_\_ Bank Draft Monthly Fee      Bank Draft      Credit Card Draft

\$ \_\_\_\_\_ Amount Paid Today      \_\_\_\_\_ Start & Expiration Dates

\_\_\_\_\_ Staff Initials