AMBULANCE, INC OF LAUREL COUNTY
WEEKLY PAYROLL DEDUCTION AUTHORIZATION

I, _____, hereby authorize Ambulance, INC of Laurel Co.
(Print name legibly)

to deduct $_____ from my weekly paycheck until further notice. I further

authorize Ambulance, INC to forward said funds to:

SUPPORTING HEROES, INC -- P. O. Box 991547 -- Louisville, KY 40269-1547.

EMPLOYEE SIGNATURE_____ EMPLOYEE or PAYROLL ID_____

MEMBERSHIP INFORMATION
(Ambulance, INC of Laurel County)

NAME_____

RANK_____

MEMBERSHIP TYPE: INDIVIDUAL_____ FAMILY_____ (see back)

MAILING ADDRESS_____

CITY/STATE/ZIP_____

EMAIL_____
(NOTE: Keeping our members informed via email helps us to keep our operating expenses to a minimum.)

PHONE (Optional)_____

AMOUNT AUTHORIZED
PER QUARTERLY PAY PERIOD: $_____ DATE:_____
NOTE: Individual membership is $120 annually ($2.31 weekly) and family membership (two adults) is $200 annually ($3.85 weekly).

FOR OFFICE USE	MMBR#	MEMB	ZIP+4	CARD	EMAIL	GROUPS	WEBSITE	PACKET	AGENCY

TO BE COMPLETED FOR FAMILY MEMBERSHIP ONLY

Family membership includes all members of a household -- including a spouse/significant other and dependent children. SUPPORTING HEROES uses the same definition of 'dependent child' as the federal government for PSOB purposes: 18 or younger; 19-22 and a full-time student; or any age if incapable of self-support due to physical or mental disability.

	NAME *as it should appear on membership card*	**BIRTHDATE** *optional for spouse / required for children*	**GENDER**	**FULL-TIME STUDENT** *if age 19 to 22*	**EMAIL**
SPOUSE			**M / F**		*Requested (but optional)*
	If spouse is in Public Safety, rank/title and agency:				
DEPENDENT CHILD			**M / F**	**Y / N**	
DEPENDENT CHILD			**M / F**	**Y / N**	
DEPENDENT CHILD			**M / F**	**Y / N**	
DEPENDENT CHILD			**M / F**	**Y / N**	
DEPENDENT CHILD			**M / F**	**Y / N**	
DEPENDENT CHILD			**M / F**	**Y / N**	