

# **WACE**

## **2017 Institutional Membership Form**

To join WACE, please return this form with payment to:

Mr. Marty Ford, Director of Global Partnerships & Programs

**WACE**

Suite 125

600 Suffolk Street

Lowell, MA 01854, USA

E-Mail: [marty\\_ford@uml.edu](mailto:marty_ford@uml.edu)

Phone: 978-934-1870

Fax: 978-934-4084

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

**MEMBER #1**

Miss \_\_\_ Ms. \_\_\_ Mrs. \_\_\_ Mr. \_\_\_ Dr. \_\_\_ Prof. \_\_\_ (please check one)

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Title: \_\_\_\_\_

Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

Province/State: \_\_\_\_\_

Postal/ZIP Code: \_\_\_\_\_

Country: \_\_\_\_\_

Business Telephone: \_\_\_\_\_

E-Mail: \_\_\_\_\_

**MEMBER #2**

Miss \_\_\_ Ms. \_\_\_ Mrs. \_\_\_ Mr. \_\_\_ Dr. \_\_\_ Prof. \_\_\_ (please check one)

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Title: \_\_\_\_\_

Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

Province/State: \_\_\_\_\_

Postal/ZIP Code: \_\_\_\_\_

Country: \_\_\_\_\_

Business Telephone: \_\_\_\_\_

E-Mail: \_\_\_\_\_

**MEMBER #3**

Miss \_\_\_ Ms. \_\_\_ Mrs. \_\_\_ Mr. \_\_\_ Dr. \_\_\_ Prof. \_\_\_ (please check one)

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Title: \_\_\_\_\_

Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

Province/State: \_\_\_\_\_

Postal/ZIP Code: \_\_\_\_\_

Country: \_\_\_\_\_

Business Telephone: \_\_\_\_\_

E-Mail: \_\_\_\_\_

**MEMBER #4**

Miss \_\_\_ Ms. \_\_\_ Mrs. \_\_\_ Mr. \_\_\_ Dr. \_\_\_ Prof. \_\_\_ (please check one)

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Title: \_\_\_\_\_

Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

Province/State: \_\_\_\_\_

Postal/ZIP Code: \_\_\_\_\_

Country: \_\_\_\_\_

Business Telephone: \_\_\_\_\_

E-Mail: \_\_\_\_\_

**MEMBER #5**

Miss \_\_\_ Ms. \_\_\_ Mrs. \_\_\_ Mr. \_\_\_ Dr. \_\_\_ Prof. \_\_\_ (please check one)

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Title: \_\_\_\_\_

Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

Province/State: \_\_\_\_\_

Postal/ZIP Code: \_\_\_\_\_

Country: \_\_\_\_\_

Business Telephone: \_\_\_\_\_

E-Mail: \_\_\_\_\_

**Annual Institutional Membership: \$500.00 (5 people)**

**Each Additional Member Under Institutional Membership: US \$ 50.00**

Additional Membership Name(s):

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Check \_\_\_ (Please send check to address on top of this form.)

MASTERCARD \_\_\_ VISA \_\_\_ (please check one)

Credit Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Cardholder Name: \_\_\_\_\_