SAMENA

• SWIM & RECREATION CLUB •

BEFORE & AFTER SCHOOL CARE

Registration Packet

2018/2019

All forms are due in completion at time of registration.

Tuition Information

Registration Form

Program Contract

Emergency Medical Form & Waiver

Certificate of Immunization (or doctor print-out)
-- Certificate of Exemption

Medication Dispensing Form

Authorization Agreement for Auto. Payment

Samena Swim and Recreation Club
15231 Lake Hills Blvd. Bellevue, WA 98007
Phone: **(425) 746-1160** Fax: **(425)746-4485**
www.samena.com
Program Director: Kristen Parkin, ext. 117
Program Manager: Jason Menia, ext. 128

2018-2019 Samena Before & After School Tuition

5 Day Monthly	Members Rate	Non-Member Rate
Before School Only	$320	$410
2nd child	$260	$325
3rd child	$150	$200
Afterschool Only	$540	$640
2nd child	$405	$490
3rd child	$260	$305
Before & After	$630	$740
2nd child	$505	$610
3rd child	$335	$385

4 Day Monthly	Members Rate	Non-Member Rate
Before School Only	$290	$345
2nd child	$235	$290
3rd child	$140	$170
Afterschool Only	$470	$570
2nd child	$370	$455
3rd child	$235	$295
Before & After	$580	$675
2nd child	$465	$535
3rd child	$300	$345

3 Day Monthly	Members Rate	Non-Member Rate
Before School Only	$230	$305
2nd child	$175	$230
3rd child	$125	$165
Afterschool Only	$405	$505
2nd child	$325	$405
3rd child	$210	$260
Before & After	$490	$615
2nd child	$390	$500
3rd child	$245	$250

2 Day Monthly	Members Rate	Non-Member Rate
Before School Only	$165	$210
2nd child	$135	$175
3rd child	$95	$110
Afterschool Only	$360	$445
2nd child	$295	$345
3rd child	$185	$220
Before & After	$425	$525
2nd child	$345	$435
3rd child	$220	$270

SAMENA
• SWIM & RECREATION CLUB •

BEFORE & AFTERSCHOOL CARE 2018-2019

Registration Form

Contact Information	
Child's Name: (First, Middle, Last)	
Parent / Legal Guardian Name:	
Email:	Phone Number(s):
Address:	
Child's Birthdate:	Age at Start of School:
Child's School:	
Registration Information	
Transportation Needed: ☐ Yes ☐ No	
Days/Time of care needed: ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐ AM ☐ PM ☐ Both	
Days: ☐ Mon ☐ Tues ☐ Weds ☐ Thurs ☐ Fri	

$110 non-refundable Registration Fee required with this form at the time of registration
Annual Transportation Fee for those needing transportation is collected at the time of registration

- $200 first child, $150 sibling, 3rd child free
- $100 for Puesta Del Sol students, $75 sibling, 3rd child free

Please note First Month and June tuition is due prior to the start of school
Please note that the June tuition is non-refundable/non transferrable once the program has begun
A 30-day notice is needed in writing to drop from the program

Office Use Only

Registration Fee:

Amount Paid: _____ Date: _____ Staff: _____

Transportation Fee(s):

Amount Paid: _____ Date: _____ Staff: _____

SAMENA

•SWIM & RECREATION CLUB•

2018-2019 Samena Before & After School Program Contract

Thank you for choosing Samena for your childcare needs. We look forward to having your child in our program this school year. Please read and sign this form and return this with your completed registration packet.

Payment Policy:

- **First month's and June tuition** is due by Monday, August 27th (if registering after the school year starts, due at time of registration).
- **Monthly tuition payments** are due by the first of the month (auto-withdrawal preferred).
- **Monthly tuition** is calculated based on the total cost of the school year and then divided by 10 months. This allows all monthly payments to be the same regardless of the number of days in the month. There is no change in tuition due to family vacations, time off etc.
- **Cancellation Policy:** A written 30-day notice before the first of the month in which you wish the changes to take place is required to cancel/switch days or drop from the program. Our before and after school year program is designed to operate on the school year calendar with a commitment for September through June.
- **June Tuition:** June tuition is non-refundable once the program has begun.

Additional Fees:

- **Registration Fee:** $110 per family is due at time of registration.
- **Annual Transportation Fee:** $200 per child ($150 for 2nd child, 3rd child free) due at registration. Puesta Del Sol students $100 ($75 for 2nd child, 3rd child free) due at registration.
- **Schedule Changes:** There is no charge to add days to your current program if space is available. There is a $50 change fee to decrease the number of days attending.
- **Non-school Days:** A separate registration process and fees apply for Bellevue School District non-school days. Registration may be handled at the Front Desk. The non-school days include winter break, mid-winter break and spring break, as well as various holidays and development days. Care for these days is not included in your tuition, but currently enrolled B&A participants receive a discount on Non-School Day Camps and extended care is included.
- **Late Pick Ups:** Our program closes at 6:30PM. A $10 fee is charged for every 10 minutes you are late past 6:30pm. The late fee is paid the day of the occurrence at the Front Desk. Please call if you will be late for any reason.

Additional Information:

- **Mandatory State Licensing Paperwork:** A completed registration packet must be on site prior to the child beginning care. (Deadline for all remaining Samena paperwork is Monday, July 16th.) This includes the registration form, medical form with signed waiver, completed immunization form, and signed contract.
- **Van Policy:** The van will wait at the school for 10 minutes at the designated loading area. If the child does not arrive within 10 minutes, the van will return to Samena and the child's parents will be contacted. It is the responsibility of the parents or school to transport a child who misses the Samena van. ***Please notify Samena by 12pm, in advance, if your child will not be attending for the day.***
- **Medication:** If your child requires medication you will need to complete the medication information sheet enclosed authorizing Samena staff to administer medications to your child. All medication must be in its original container with written directions / dose and time for your child.
- **Communication:** For your child's safety, we ask that you provide in writing any changes to your emergency contacts including address and phone changes.

I/we also agree to the Terms of the Samena Club Before and After School Care as listed on this contract. I have read and understand the terms of this agreement. I have received a copy of the Samena Club Before and After School Care Rules and Regulations and guidelines. I agree that I and all persons participating in the Samena Club Before and After School Care are bound by and shall comply with the rules and regulations of the Club as they may be amended from time to time.

Printed Name_____ Signature_____ Date_____

Samena Before & Afterschool Care Medical Form

Last Name:	First Name:	Middle:
Birthdate (MM/DD/YYYY):		Nickname?
Street Address:	City:	Zip Code:
Child's Parent/Guardian Name(s):		
Cell Phone:	Home Phone:	Additional Phone:
(Alternate) Street Address:	City:	Zip Code:
Address of where we can reach you while child is in care:		

Authorized Pick Up		
(Fill in below line) Name / Relationship:	Address:	Telephone Numbers:
(Fill in below line) Name / Relationship:	Address:	Telephone Numbers:
(Fill in below line) Name / Relationship:	Address:	Telephone Numbers:
(Fill in below line) Name / Relationship:	Address:	Telephone Numbers:
In case of an emergency, I give permission for any of the following individuals to be contacted, and my child may be released to any of them: Parent Signature: _____		
Name / Relationship:	Phone Number:	
Name / Relationship:	Phone Number:	
Who does not have permission to pick up your child? If applicable: **(A copy of supporting court document must be on file)**		
Name:		
Reason:		
If more, please attach separate sheet		

Child's Health Information

Child's Health Care Provider:	Phone Number:	
Date of Child's Last Physical Exam:		
Street address:	City:	Zip Code:
Special health problems? Yes or no? If yes, please specify:		
Allergies, including drug reaction Yes or No? If yes, specify:		
Child's Dentist Name:	Phone Number:	
Date of Child's Last Dental Exam:		
Street Address:	City:	Zip Code:

Child's Medical Insurance

Insurance Company:	Member/Policy Number:
Policy Holder Name:	Employer Name:
Insurance Company:	Member/Policy Number:
Policy Holder Name:	Employer Name:

Consent to Medical Care, Treatment of Minor Children, and Program Waivers

I _____ (Parent / Legal Guardian) herby give permission that my child, _____ may be given emergency treatment to include first aid and CPR by a qualified staff member at Samena Club. I further authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safeguard my child's health in case I cannot be contacted. I waive my right of informed consent of such treatment. I give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment.

I give permission for him/her to participate in the Samena Club's Children's Program activities/outings and be transported by the Samena vans. I hereby release the Samena Club and its officers and employees from any legal responsibility should a question of liability occur.

I provide permission for the Samena Club to use any pictures of my child in future promotional purposes for the Samena Club only (photos will not be sold) unless denied in writing and attached to this form.

Signature of parent or legal guardian: _____ Date: _____

Printed name of parent or legal guardian: _____

Certificate of Immunization Status (CIS)

For Kindergarten-12th Grade / Child Care Entry

Office Use Only:	
Reviewed by:	Date:
Signed Cert. of Exemption on file? ❑ Yes ❑ No	

Please print. See back for instructions on how to fill out this form or get it printed from the Washington Immunization Information System.

Child's Last Name: **First Name:** **Middle Initial:** **Birthdate** (MM/DD/YY)**:** **Sex:**

I give permission to my child's school to share immunization information with the Immunization Information System to help the school maintain my child's school record.

Parent/Guardian Signature Required **Date**

I certify that the information provided on this form is correct and verifiable.

Parent/Guardian Signature Required **Date**

♦ Required for School and Child Care/Preschool
● Required Only for Child Care/Preschool

	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY
Required Vaccines for School or Child Care Entry						
♦ **DTaP / DT** (Diphtheria, Tetanus, Pertussis)						
♦ **Tdap** (Tetanus, Diphtheria, Pertussis)						
♦ **Td** (Tetanus, Diphtheria)						
♦ **Hepatitis B** ❑ 2-dose schedule used between ages 11-15						
● **Hib** (*Haemophilus influenzae* type b)						
♦ **IPV / OPV** (Polio)						
♦ **MMR** (Measles, Mumps, Rubella)						
● **PCV / PPSV** (Pneumococcal)						
♦ **Varicella** (Chickenpox) ❑ History of disease verified by IIS						
Recommended Vaccines (Not Required for School or Child Care Entry)						
Flu (Influenza)						
Hepatitis A						
HPV (Human Papillomavirus)						
MCV / MPSV (Meningococcal)						
MenB (Meningococcal)						
Rotavirus						

Documentation of Disease Immunity

Healthcare provider use only

If the child named in this CIS has a history of Varicella (Chickenpox) or can show immunity by blood test (titer) it MUST be verified by a healthcare provider

I certify that the child named on this CIS has:

❑ a verified history of Varicella (Chickenpox).

❑ laboratory evidence of immunity (titer) to disease(s) marked below. **Lab report(s) for titers MUST also be attached.**

❑ Diphtheria	❑ Mumps	❑ Other:
❑ Hepatitis A	❑ Polio	_____
❑ Hepatitis B	❑ Rubella	_____
❑ Hib	❑ Tetanus	
❑ Measles	❑ Varicella	

Licensed healthcare provider signature (MD, DO, ND, PA, ARNP) Date

Printed Name

Instructions for completing the Certificate of Immunization Status (CIS): printing it from the Immunization Information System (IIS) or filling it in by hand.

To print with immunization information filled in: Ask if your healthcare provider's office enters immunizations into the WA Immunization Information System (Washington's statewide database). If they do, ask them to print the CIS from the IIS and your child's immunization information will fill in automatically. You can also print a CIS at home by signing up and logging into MyIR at https://wa.myir.net. **If your provider doesn't use the IIS, email or call the Department of Health to get a copy of your child's CIS: waiisrecords@doh.wa.gov or 1-866-397-0337.**

To fill out the form by hand:

#1 Print your child's name, birthdate, sex, and sign your name where indicated on page one.

#2 Vaccine information: Write the date of each vaccine dose received in the date columns (as MM/DD/YY). If your child receives a combination vaccine (one shot that protects against several diseases), use the Reference Guides below to record each vaccine correctly. For example, record Pediarix under Diphtheria, Tetanus, Pertussis as **DTaP**, Hepatitis B as **Hep B**, and Polio as **IPV**.

#3 History of Varicella Disease: If your child had chickenpox (varicella) disease and not the vaccine, **a health care provider must verify chickenpox disease to meet school requirements**.

- ❑ If your healthcare provider can verify that your child had chickenpox, ask your provider to check the box in the Documentation of Disease Immunity section and sign the form.
- ❑ If school staff access the IIS and see verification that your child had chickenpox, they will check the box under Varicella in the vaccines section.

#4 Documentation of Disease Immunity: If your child can show positive immunity by blood test (titer) and has not had the vaccine, have your healthcare provider check the boxes for the appropriate disease in the Documentation of Disease Immunity box, and sign and date the form. **You must provide lab reports with this CIS**.

Reference guide for vaccine abbreviations in alphabetical order For updated list, visit https://fortress.wa.gov/doh/cpir/iweb/homepage/completelistofvaccinenames.pdf

Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name
DT	Diphtheria, Tetanus	Hep A	Hepatitis A	MCV / MCV4	Meningococcal Conjugate Vaccine	OPV	Oral Poliovirus Vaccine	Tdap	Tetanus, Diphtheria, acellular Pertussis
DTaP	Diphtheria, Tetanus, acellular Pertussis	Hep B	Hepatitis B	MenB	Meningococcal B	PCV / PCV7 / PCV13	Pneumococcal Conjugate Vaccine	VAR / VZV	Varicella
DTP	Diphtheria, Tetanus, Pertussis	Hib	*Haemophilus influenzae* type b	MPSV / MPSV4	Meningococcal Polysaccharide Vaccine	PPSV / PPV23	Pneumococcal Polysaccharide Vaccine		
Flu (IIV)	Influenza	HPV (2vHPV / 4vHPV / 9vHPV)	Human Papillomavirus	MMR	Measles, Mumps, Rubella	Rota (RV1 / RV5)	Rotavirus		
HBIG	Hepatitis B Immune Globulin	IPV	Inactivated Poliovirus Vaccine	MMRV	Measles, Mumps, Rubella with Varicella	Td	Tetanus, Diphtheria		

Reference guide for vaccine trade names in alphabetical order For updated list, visit https://fortress.wa.gov/doh/cpir/iweb/homepage/completelistofvaccinenames.pdf

Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine
ActHIB®	Hib	Fluarix®	Flu	Havrix®	Hep A	Menveo®	Meningococcal	Rotarix®	Rotavirus (RV1)
Adacel®	Tdap	Flucelvax®	Flu	Hiberix®	Hib	Pediarix®	DTaP + Hep B + IPV	RotaTeq®	Rotavirus (RV5)
Afluria®	Flu	FluLaval®	Flu	HibTITER®	Hib	PedvaxHIB®	Hib	Tenivac®	Td
Bexsero®	MenB	FluMist®	Flu	Ipol®	IPV	Pentacel®	DTaP + Hib + IPV	Trumenba®	MenB
Boostrix®	Tdap	Fluvirin®	Flu	Infanrix®	DTaP	Pneumovax®	PPSV	Twinrix®	Hep A + Hep B
Cervarix®	2vHPV	Fluzone®	Flu	Kinrix®	DTaP + IPV	Prevnar®	PCV	Vaqta®	Hep A
Daptacel®	DTaP	Gardasil®	4vHPV	Menactra®	MCV or MCV4	ProQuad®	MMR + Varicella	Varivax®	Varicella
Engerix-B®	Hep B	Gardasil® 9	9vHPV	Menomune®	MPSV4	Recombivax HB®	Hep B		

If you have a disability and need this document in another format, please call 1-800-525-0127 (TDD/TTY call 711).

DOH 348-013 December 2016

Washington State Department of Health

DOH 348-106 Jan 2015

Certificate of Exemption

SIDE A:
For Religious, Personal, Philosophical, and Medical Exemptions[1]

FOR OFFICE USE ONLY CHILD'S LAST NAME _____ FIRST NAME _____ M.I. _____

PART 1: PARENT OR GUARDIAN INSTRUCTIONS

In order for this form to be valid for religious, personal, philosophical, or medical reasons, please:

Step 1: Fill in your child's information in Boxes 1-4
Step 2: Read the Parent/Guardian Declaration
Step 3: Provide your initials where indicated
Step 4: Print your name, sign, and date in Boxes 5-6
Step 5: Have a provider complete Part 2 of this form

1. Child's Last Name

2. Child's First Name and Middle Initial

3. Birthdate (mm/dd/yyyy) _____/_____/_____

4. Gender
☐ Male
☐ Female

I am the parent or legal guardian of the above named child. One or more required vaccines are in conflict with my personal, philosophical, or religious beliefs.

Parent/Guardian Declaration

I understand that:

- *My child may not be allowed to attend school or child care during an outbreak of the disease that my child has not been fully vaccinated against.* _____ ***(initial)***
- *Exempting my child from any or all required vaccine(s) may result in serious illness, disability, or death to my child or others. I understand the risks and possible outcomes of my decision to exempt my child.* _____ ***(initial)***
- *The information provided on this form is complete and correct.* _____ ***(initial)***

5. Print Parent/Guardian Name

6. Parent/Guardian Signature and Date _____/_____/_____

PART 2: HEALTHCARE PROVIDER INSTRUCTIONS

In order for this form to be valid, please:

Step 1: Mark which disease(s) and what type of exemption is requested. If medical write a **T** for Temporary or **P** for Permanent.
Step 2: Discuss the benefits and risks of immunizations with the parent or guardian
Step 3: Read the Provider Declaration
Step 4: Print your name, credentials, sign, and date in Boxes 7-8

Vaccine	Personal/ Philosophical	Religious	Medical (T/P)**	Expiration Date for Temporary Medical
Diphtheria				
Hepatitis B				
Hib				
Measles				
Mumps				
Pertussis				
Pneumococcal				
Polio				
Rubella				
Tetanus				
Varicella				
All				

***A provider may grant a medical exemption only if there is a medical contraindication to a vaccine.*

Provider Declaration

I declare that:

- *I have discussed the benefits and risks of immunizations with the parent/legal guardian as a condition for exempting their child.*
- *I am a qualified MD, ND, DO, ARNP or PA licensed under Title 18 RCW.*
- *The information provided on this form is complete and correct.*

7. Print Provider Name and Credential **(MD, ND, DO, ARNP, PA)**

8. Provider Signature and Date _____/_____/_____

[1]RCW 28A.210.080-090 "Before or on the first day of every child's attendance at any public and private school or licensed child care center in Washington State, the parent or guardian must present proof of either: (1) full immunization, (2) the initiation of and compliance with a schedule of immunization, as required by rules of the State Board of Health, or (3) a certificate of exemption signed by a parent or guardian and is either A) signed by a licensed healthcare provider or B) demonstrates membership in a church or religious body that precludes healthcare practitioners from providing medical treatment to children."

Washington State Department of Health

Certificate of Exemption

SIDE B:
For Religious Membership Exemption ONLY

FOR OFFICE USE ONLY CHILD'S LAST NAME FIRST NAME M.I.

NOTICE: Complete this side if you belong to a church or religion that objects to the use of medical treatment.[1]

If you have a religious objection to vaccinations, but the beliefs or teachings of your church or religion allow for your child to be treated by medical professionals such as doctors and nurses, then you must use Side A of this Certificate of Exemption.

PARENT OR GUARDIAN INSTRUCTIONS

In order for this form to be legally valid for religious membership reasons, please:

Step 1: Fill in your child's information in Boxes 1-4
Step 2: Read the Parent/Guardian Declaration and provide your initials where indicated
Step 3: Provide the name of the church or religion of which you are a member, and print your name, sign, and date in Boxes 5-7

1. Child's Last Name

2. Child's First Name and Middle Initial

3. Birthdate (mm/dd/yyyy)
_____/_____/_____

4. Gender
☐ M ☐ F

I am the parent or legal guardian of the above named child and I am exempting my child from all required vaccinations.

Parent/Guardian Declaration

I understand that:

- *My child may not be allowed to attend school or child care during an outbreak of the disease that my child has not been fully vaccinated against.* _____ ***(initial)***
- *Exempting my child from all required vaccines may result in serious illness, disability, or death to my child or others. I understand the risks and possible outcomes of my decision to exempt my child.* _____ ***(initial)***
- *The information provided on this form is complete and correct.* _____ ***(initial)***

I affirm that I am a member of a church or religion whose teachings preclude healthcare practitioners from providing any medical treatment to my child.

5. Name of Church or Religion of Which You Are a Member

6. Print Parent/Guardian Name

7. Parent/Guardian Signature and Date
_____/_____/_____

[1]RCW 28A.210.090 "The parent of legal guardian demonstrates membership in a religious body or a church in which the religious beliefs or teachings of the church preclude a health care practitioner from providing medical treatment to the child."

Samena Swim &Recreation Club

Medication Dispensing Form

Child's Name _____

Reason for Medication:_____

Name of Medication: _____

How much to give: _____

When to give: _____

How to give:

____Oral (by mouth)
____Topical (to skin)
____Other (please explain)_____

When the treatment should be stopped: _____

Requires Refrigeration: _____Yes _____No

Possible side effects:_____

Special instructions/suggestions (e.g. take with food, with water etc.):
_____

Parent signature_____ Date_____

*Note: You need a physician's signature for non-prescription medications if:

1. There are no instructions on the container for use of the medication for child's age or
2. The medication is **not** listed below:

- Antihistamines (Benadryl, Sudafed)
- Non-aspirin pain relievers and fever reducers (Tylenol, Datril, Liquiprin)
- Cough medicines (Robitussin, Triaminic)
- Decongestants (Dimetapp, Pediacare, Robitussin)
- Anti-itching creams (Caladryl, Delacort)
- Sunscreens (recommended to be applied by a parent/guardian)

AUTHORIZATION AGREEMENT FOR
CREDIT or DEBIT CARD (EFT) AUTOMATIC PAYMENTS

For Automatic Payment from Bank Account (ACH), please fill out reverse side instead

Company: **SAMENA CLUB**

I (we) hereby authorize Samena Club or its authorized credit/debit card transaction agent(s) to bill my credit/debit card account indicated below for monthly payment.

Credit/Debit Card type: (Please circle one) Visa Mastercard Discover AmEx

- Last 4 digits of credit card # ___ ___ ___ ___
- Expiration Date: ___ ___ /___ ___
- CVV# (3 or 4 digits): ___ ___ ___ ___
- Name on Card: _____
- Street Address credit card statement is sent to: _____
- Zip Code: _____

This authority is to remain in full force and effect until Samena Club has received written notification from me (or either of us) of its termination in such time and in such manner as to afford Samena Club and the DEPOSITORY a reasonable opportunity to act on it. If I change the account number or financial institution specified, I will provide written authorization for the change to Samena Club.

Membership Number: _____

Primary Member Name: (Please Print) _____

Primary Member Signature: _____Date Signed:_____

Spouse: (if applicable)

Spouse Name: (Please Print or Type) _____

Spouse Signature: _____Date Signed: _____

15231 Lake Hills Blvd. Bellevue WA 98007
Attn: Rachel Perez (425) 746-1160 ext 124 rachelp@samena.com

AUTHORIZATION AGREEMENT FOR
ACH (Bank Account) AUTOMATIC PAYMENTS

For Automatic Payment from Credit/Debit Card (EFT), please fill out reverse side instead

Company: SAMENA CLUB **Type of Account: □ Checking □Savings**

I (we) hereby authorize Samena Club to initiate an electronic debit to my (our) account identified below and its depository (bank), to debit the same to said account.

Depository Name: _____Branch _____

City, State, Zip:

_____

Transit/Routing No. □:__ __ __ __ __ __ __ __ __ □: Account No. _____
(first 9 numbers on bottom left of check)

I have read and agree to the terms of this application. This authorization is to remain in full force and effect until Samena Club and its DEPOSITORY have received written notification from me (or either of us) of its termination in such time and in such manner as to afford Samena Club and its DEPOSITORY a reasonable opportunity to act on it.

I further understand that it is my sole responsibility to maintain sufficient available funds in my account to provide for payment to Samena Club on the due date. In the vent that there are insufficient funds in the account and my financial institution denies payment to Samena Club, I understand that Samena Club will add a $10.00 service fee to my account.

Membership Number: _____

Primary Member Name: (Please Print or Type)

_____

Primary Member Signature: _____Date Signed:_____

Spouse: (if applicable)

Spouse Name: (Please Print or Type)

_____

Spouse Signature: _____Date Signed: _____

(ATTACH VOIDED CHECK)

15231 Lake Hills Blvd. Bellevue WA 98007
Attn: Rachel Perez (425) 746-1160 ext 124 rachelp@samena.com