Congregation Shaaray Tefila

68 Bay Street
Glens Falls, NY 12801
(518) 792-4945

Today's Date: _____

APPLICATION FOR MEMBERSHIP
(PLEASE PRINT)

NAME: _____

ADDRESS: _____

_____

HOME PHONE NUMBER: _____

WORK PHONE NUMBER: _____

CELL PHONE NUMBER: _____

EMAIL ADDRESS: _____

ADULTS:

NAME: _____ HEBREW NAME: _____

Date of birth: _____ Place of birth: _____

Father's full name-English: _____ Hebrew: _____

Mother's full name-English: _____ Hebrew: _____

If either parent is deceased, please state date of death (s):

Father: _____ Mother: _____
(English) month day year (English) month day year

……

NAME: _____ HEBREW NAME: _____

Date of birth: _____ Place of birth: _____

Father's full name-English: _____ Hebrew: _____

Mother's full name-English: _____ Hebrew: _____

If either parent is deceased, please state date of death (s):

Father: _____ Mother: _____
(English) month day year (English) month day year

……

CHILDREN:

NAME: _____ HEBREW: _____ DATE OF BIRTH: _____

NAME: _____ HEBREW: _____ DATE OF BIRTH: _____

NAME: _____ HEBREW: _____ DATE OF BIRTH: _____

NAME: _____ HEBREW: _____ DATE OF BIRTH: _____

NAME: _____ HEBREW: _____ DATE OF BIRTH: _____

ADDITIONAL DATA:
Please record any other information that you feel may be of value and that you would want to be kept in the archives of the Congregation.

State current activities of our Synagogue in which you are most interested:

ADULTS: _____

_____

CHILDREN: _____

Please suggest additional activities which you would like our Synagogue to institute:

_____

_____

_____

Enclosed please find check# _____ in the amount of $_____for one year's due.

_____ _____
(signature) (signature)