VOSH-MN MEMBERSHIP:

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

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

E-mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes, I want to be a member / make a donation

           \_\_\_\_: Basic Membership $50

           \_\_\_\_: Additional Donation (THANK YOU!)

           \_\_\_\_: I will pay [online](https://voshminnesota.org/forms/donate/).

(   )My clinic would love to sponsor a workshop.

           \_\_\_\_:  I have enough glasses to verify and some lensometers.

           \_\_\_\_:  I will need to have glasses and lensometers provided.

(   )Please sign me up to help with social media and marketing.

(   )I have some fun ideas and would love to be part of a think tank.

(   )Please put me on the list for upcoming trips.

Other:   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please remit form and payment to:**

**VOSH-MN**

**c/o Dr. Alex Paradis (Treasurer)**

**2155 246th Street**

**St. Augusta, MN  56301**