



5771 (2010-2011) Membership Family Record

(Returning members need not submit this form if no changes are necessary)

	Adult Member A	Adult Member B
Title (Dr., Mr., Mrs., Ms., etc.)		
Full Name		
Hebrew Name		
Address:	City:	St: Zip:
Home Phone: ()	Fax: ()	
Cell Phone:	()	()
E-Mail:		
Birthday:	/ / : am/pm	/ / : am/pm
Anniversary: / /	Returning: <input type="checkbox"/> No <input type="checkbox"/> Yes	Date First Joined: / /
Occupation:	Job Title:	Job Title:
	Employer:	Employer:
	Phone: ()	Phone: ()
Do you read Hebrew?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Some	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Some
Do you wish to participate in services?	<input type="checkbox"/> No <input type="checkbox"/> English Section <input type="checkbox"/> Aliyot <input type="checkbox"/> Hebrew Section <input type="checkbox"/> Torah Portion	<input type="checkbox"/> No <input type="checkbox"/> English Section <input type="checkbox"/> Aliyot <input type="checkbox"/> Hebrew Section <input type="checkbox"/> Torah Portion
How did you hear about Congregation B'nai Emet? <input type="checkbox"/> Word of Mouth <input type="checkbox"/> Newspaper Ad <input type="checkbox"/> Flyer		
Would you like to receive mail or publications from other Jewish organizations? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Children				
Name (first, last):				
Hebrew Name:				
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth:				
Address:				
Hebrew School:	Grade: <input type="checkbox"/> No	Grade: <input type="checkbox"/> No	Grade: <input type="checkbox"/> No	Grade: <input type="checkbox"/> No
Religious School:	Grade: <input type="checkbox"/> No	Grade: <input type="checkbox"/> No	Grade: <input type="checkbox"/> No	Grade: <input type="checkbox"/> No
Bar/Bat Mitzvah Date:				
Youth Group Member:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Contact me	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Contact me	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Contact me	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Contact me

Yahrzeits (Anniversary of Death)				
Name	Hebrew Name	Relationship	To Whom	Date of Death
				/ /
				/ /
				/ /
				/ /