



Membership Application

Mail to:
MBPA
P.O. Box 2394
Malta, NY 12020-8394

Membership Fee \$65.00

Date _____ New Member _____ Renewal _____

Organization Name _____

Name of representative _____

Title _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____ E-mail _____

Website _____

Describe Business/Service (10 words or less) _____

Are you willing to provide other MBPA members a courtesy discount on your products/services? Y N

Details of discount offered _____
