**Name:**

For Office Use Only

Paid \_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_

Chk # \_\_\_\_\_\_\_\_ Bal Due: \_\_\_\_\_\_\_

DB: \_\_\_\_\_\_\_\_ CC: \_\_\_\_\_\_\_

Bull: \_\_\_\_\_\_\_\_ Nat’l: \_\_\_\_\_\_\_

Please return with your payment to the **Membership Desk** or mail to:

Minneapolis Branch AAUW

2115 Stevens Ave S

Minneapolis MN 55404

**Member Renewal Form---PAYMENT DUE**

\_\_\_\_ $295 Regular (Includes $212.00 Branch, $9.00 State, $74.00 National (Dues are deductible)

\_\_\_\_ $221 PAID LIFETIME

\*Regular Dues may be paid in three installments of $95/$100/$100.

**Total Branch Dues: $\_\_\_\_\_\_\_\_\_\_\_\_\_**

Branch Tax-deductible Donations **Total Branch Donations $ \_\_\_\_\_\_\_\_\_\_\_\_**

I am enclosing a check made out to AAUW Minneapolis for: **Dues + Contributions: $\_\_\_\_\_\_\_\_\_\_\_\_\_**

**AAUW Minneapolis Branch Scholarship – Tax Deductible**

AAUW Minneapolis Scholarship: Please Check One: \_\_\_\_\_\_\_\_ Endowment \_\_\_\_\_\_\_\_ Current

**I am enclosing a separate check made out to AAUW Minneapolis Scholarship Fund $\_\_\_\_\_\_\_\_\_\_\_\_\_**

**National AAUW Funds Donation - Tax Deductible**

$\_\_\_\_\_\_ AAUW Greatest Needs Funds

(AAUW utilizes your gift where most needed)

$\_\_\_\_\_\_ Education and Training Fund

(Fellowship, public Policy, Research

$\_\_\_\_\_\_ Economic Security Fund

(Legal Advocacy, Title IX, Work Smart)

$\_\_\_\_\_\_ Leadership Programs Fund

(NCCWSL, Campus Action Projects)

**I am enclosing a separate check made out to AAUW FUNDS: Total National Contributions: $\_\_\_\_\_\_\_\_\_\_\_\_\_**

**OR I am donating online to these funds Total National Contributions: $\_\_\_\_\_\_\_\_\_\_\_\_\_**

If there has been a change in your Emergency Contact Information, please complete.

Name of Contact Person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctors Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctors Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_