FLACA

Florida AUTO CARE ALLIANCE

Allied Membership Application

Company Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (_____) _____ Fax (_____) _____

Web Site Address _____ E-Mail Address _____

Primary Contact _____ Title _____

Primary Mailing Address _____

City: _____ State: _____ Zip: _____

Contact Cellphone (_____) _____ E-Mail Address _____

Nature of Business: ☐ Training ☐ Manufacturer ☐ Supplier-Parts ☐ Supplier-Equipment ☐ Other _____

Division: ☐ Mechanical ☐ Collision ☐ Mechanical & Collision

Brief description on your product/service
(To be included on the allied member directory)

_____

_____

_____

_____

Credit Card # _____ Exp Date _____ CVC _____

Billing City, State, Zip _____

ALLIED MEMBER DUES: $250 (serving no more than 3 counties) / $500 (serving entire state of FL)

If paying your dues in full by check, please mail application & check payable to FLACA for the amount of $350.00 to the address below

I, the undersigned, as a member of the Florida Auto Care Alliance will abide by the Association's bylaws, membership in the association is non-refundable and non-transferable. I also understand that the membership dues may be deductible as a business expense for Federal income tax purpose,s but are not deductible as a charitable contribution. I also understand that the FLACA logo is a registered trademark and the property of ACA and should be used in accordance with the ACA Sign and Logo policy.

Signature: _____ Date: _____

Florida Auto Care Alliance
332 SE Tressler Drive, Stuart, FL 34994
772.444.2272 816.817.2260 (fax)
info@floridaautocare.org www.floridaautocare.org

FOR OFFICE USE ONLY

Join Date: _____

Billing Start Date: _____

Next Bill Date: _____

Enrolled By: _____