Celtic Warmblood Registry

Membership Application

Date: _____

First Name: _____ Last Name: _____

Mailing
Address : _____

City : _____

State / Region: _____ Postal Code : _____ Country : _____

Email Address: _____

Comments : _____

_____

Please complete and submit the application along with $ 25.00 annual membership fees made payable to Celtic Warmblood Registry. Please do not enclose cash. Payment may be made via check, money order, Visa or Master Card.

Credit Card Information : __ Visa ___ Master Card

Credit Card Number: _____ Exp Date (MM/YY) ___/___

Please complete information above if payment is by credit card.

Mail to: Celtic Warmblood Registry
C/O Registrar
PO Box 148
Fulshear, TX 77441