***Civil Air Patrol Flying Association, Inc (CAPFA)***
**Membership application**

Name _____ Age _____

Home Address _____

City _____ State _____ Zip _____

Telephone Number (C) _____ (H) _____

Email Address _____

Employer Name _____ Employer Address _____

City _____ State _____ Zip _____

Work Telephone Number _____

In case of emergency notify _____ Relationship _____ Phone number_____

**Airman's Status**

Student _____ Full name of instructor _____

Private _____ Commercial _____ Instrument _____ Other _____

Flying Experience: Number of years _____ Total hours _____ Last 90 days _____

Type of aircraft flown _____

Medical Class _____ Expiration Date _____ Medical Limitations or Waivers (please list) _____

Have you EVER had an accident? _____ Incident? _____

Pilot's license or medical certificate ever revoked or suspended? _____ (please list) _____

When will most of your flying be done? Weekdays _____ Weekends _____ Nights _____

How did you hear about CAPFA? _____

Signature _____ Date _____