



Combat Helicopter Pilots Association Membership Application

Contact Information

Name (Rank/Mr./Ms.) _____ Date of Birth _____
 Name You Prefer to Go By _____
 Address Line 1 _____ Address Line 2 _____
 City _____ State _____ Zip _____
 Home Phone _____ Work Phone _____
 E-Mail _____

Military Aviation Information: Please provide as much information as possible, particularly when applying for Pilot Membership

Flight School Class & No. _____ Branch of Service _____
 Combat Flight Hours _____ Total Flight Hours _____
 Combat Helicopter Tour Date(s) (List From/To for All) _____
 Call Sign(s) _____ Unit(s) _____
 Location or Theater _____ Combat Acft Flown (List All) _____

Optional Information

Career Helicopter Qualifications (Other Than Military) _____
 Medals/Awards _____ Hobbies _____
 How Did You Learn About CHPA? _____
 Current Employer and Position _____
 Name & E-Mail of a Friend Who May Wish to Join _____
 Related Associations to Which You Belong _____

Membership Type and Dues

Annual Membership will be billed each year prior to your anniversary date. Lifetime dues are charged only once. Please refer to the CHPA Web site (<http://www.chpa-us.org>) for complete membership definitions.

- Pilot Annual - \$30 Flight Crew Annual - \$30 Friend of CHPA, Individual- \$30 Legacy*
 Pilot Lifetime - \$650 Flight Crew Lifetime - \$650 Friend of CHPA, Corporate - \$50

* For Legacy Members, Qualifying deceased family member information

Name _____ Relationship _____ Service _____ Aircraft _____

I, the undersigned, certify that the above information is true and correct. I understand that my membership application will be reviewed by the CHPA Board and that, upon approval, my payment will be processed. If membership is denied, my payment will be returned to my attention.

Payment

If you are paying by check, please make payable to CHPA and return your application and payment to: CHPA, P.O. Box 42, Divide, CO 80814-0042. If you would like to pay by credit card, please complete the information below and mail this application, or fax it to 719-687-4167.

Credit Card AMEX MC VISA
 Card Number _____
 Expiration Date _____ Security Code _____
 Signature _____

For Official Use Only			
Accepted on _____	By _____		
Payment Received _____	Yes _____	No _____	
Payment Type _____	Check _____	CC _____	Cash _____

Please call 800-832-5144 or E-Mail hq@chpa-us.org if you have any questions. Thank you.

We acknowledge that the information we provide on this application may be used by CHPA for publishing an online and/or printed directory, E-Mail or fax communications to and from the membership. ___ Please check here if you do not wish to receive E-Mail.