# Individual Membership Form

**Please Print**

Last Name _____ First Name _____

Position _____ Training Facility_____

Mailing Address _____

City/State/Zip _____

Business Phone _____Email _____

Type of Program:

☐ Secondary ☐ Post-Secondary Public ☐ Post-Secondary Private

☐ Corporate/Other

Which nationally-recognized HVACR exams have you passed? Check all that apply.

☐ ACE Technician Exam
☐ HVAC Excellence Exam
☐ ICE Exam
☐ NATE Exam
☐ RSES Exam
☐ Other _____

***Membership in CARE is on an annual basis from March to February each year.***

Signature: _____ Date:_____

Include a check in the amount of **$25.00 USD** payable to:
Council of Air Conditioning & Refrigeration Educators (CARE)
and mail with this form to

CARE Treasurer
11018 Forty Corners ST NW
Massillon Ohio 44647