



Congregation Beth Tefillah, a Chabad Synagogue

5065 High Point Road • Atlanta, GA 30342 • 404-843-2464

Membership Application



ADULT MEMBER ONE

Last Name:		Mr. Mrs. Ms. Dr. Rabbi First Name:			Middle Name:	
Home Address:		City:	State:	Zip:	<input type="checkbox"/> Bills? <input type="checkbox"/> Mail?	
Secondary Address:		City:	State:	Zip:	<input type="checkbox"/> Bills? <input type="checkbox"/> Mail?	
Date of Birth: Month:	Day:	Year:	<input type="checkbox"/> after sunset	Home Phone:		
Cell Phone:			E-mail Address:			
Occupation:		Work phone:		Address:		
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			Anniversary date:			
Hebrew Name:			<input type="checkbox"/> Kohen	<input type="checkbox"/> Levi	<input type="checkbox"/> Yisroel	
Jewish Status: <input type="checkbox"/> Born Jewish <input type="checkbox"/> Converted to Judaism <input type="checkbox"/> Not Jewish						
Conversion Date:		Place:	Rabbi & Affiliation:			
Bar/Bat Mitzvah: Parsha:		Haftarah:	Date:			
Information about your father: Name: Mr., Dr., Rabbi					Hebrew Name:	
Jewish Status: <input type="checkbox"/> Born Jewish <input type="checkbox"/> Converted to Judaism <input type="checkbox"/> Not Jewish						
Conversion Date		Place:	Rabbi & Affiliation:			
Information about your mother: Name: Mrs., Dr., Rabbi					Hebrew Name:	
Jewish Status: <input type="checkbox"/> Born Jewish <input type="checkbox"/> Converted to Judaism <input type="checkbox"/> Not Jewish						
Conversion Date		Place:	Rabbi & Affiliation:			

ADULT MEMBER TWO

Last Name:		Mr. Mrs. Ms. Dr. Rabbi First Name:			Middle Name:	
Date of Birth: Month:	Day:	Year:	<input type="checkbox"/> after sunset			
Cell Phone:			E-mail Address:			
Occupation:		Work phone:		Work Address:		
Hebrew Name:			<input type="checkbox"/> Kohen	<input type="checkbox"/> Levi	<input type="checkbox"/> Yisroel	
Jewish Status: <input type="checkbox"/> Born Jewish <input type="checkbox"/> Converted to Judaism <input type="checkbox"/> Not Jewish						
Conversion Date:		Place:	Rabbi & Affiliation:			
Bar/Bat Mitzvah: Parsha:		Haftarah:	Date:			
Information about your father: Name: Mr., Dr., Rabbi					Hebrew Name:	
Jewish Status: <input type="checkbox"/> Born Jewish <input type="checkbox"/> Converted to Judaism <input type="checkbox"/> Not Jewish						
Conversion Date		Place:	Rabbi & Affiliation:			
Information about your mother: Name: Mrs., Dr., Rabbi					Hebrew Name:	
Jewish Status: <input type="checkbox"/> Born Jewish <input type="checkbox"/> Converted to Judaism <input type="checkbox"/> Not Jewish						
Conversion Date		Place:	Rabbi & Affiliation:			
Former Synagogue Affiliation:			Concurrent Synagogue Affiliation:			

Membership Category Select One:

- Family Membership
 Family (under age 30)
 Single (under age 30)
 Senior Membership (65+)
 Single Parent
 Associate (requires concurrent synagogue affiliation)

I agree to comply with all of the rules and regulations of Congregation Beth Tefillah. I agree to meet all financial obligations associated with this membership. I understand that any request for reductions in dues on account of financial hardship must be discussed with the Executive Director and that such requests are subject to the approval of the appropriate committee.

Signature _____ Date _____

Complete as many pages as needed for all your DEPENDENT children

Child Number ____

<input type="checkbox"/> Male	<input type="checkbox"/> Female	Date of Birth: Month	Day	Year	<input type="checkbox"/> After Sunset
Name: First		Middle		Last	
Hebrew Name: (transliteration)					<input type="checkbox"/> Kohen <input type="checkbox"/> Levi <input type="checkbox"/> Yisroel
Bar/Bat Mitzvah: Parsha:		Haftorah:		Date:	B/M Date:
E-Mail Address:				Cell Phone:	
Jewish Status: <input type="checkbox"/> Born Jewish		<input type="checkbox"/> Converted to Judaism		<input type="checkbox"/> Not Jewish	
Conversion Date:		Place:		Rabbi & Affiliation:	
Relationship to Member 1: <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Other			Relationship to Member 2: <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Other		

Child Number ____

<input type="checkbox"/> Male	<input type="checkbox"/> Female	Date of Birth: Month	Day	Year	<input type="checkbox"/> After Sunset
Name: First		Middle		Last	
Hebrew Name: (transliteration)					<input type="checkbox"/> Kohen <input type="checkbox"/> Levi <input type="checkbox"/> Yisroel
Bar/Bat Mitzvah: Parsha:		Haftorah:		Date:	B/M Date:
E-Mail Address:				Cell Phone:	
Jewish Status: <input type="checkbox"/> Born Jewish		<input type="checkbox"/> Converted to Judaism		<input type="checkbox"/> Not Jewish	
Conversion Date:		Place:		Rabbi & Affiliation:	
Relationship to Member 1: <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Other			Relationship to Member 2: <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Other		

Child Number ____

<input type="checkbox"/> Male	<input type="checkbox"/> Female	Date of Birth: Month	Day	Year	<input type="checkbox"/> After Sunset
Name: First		Middle		Last	
Hebrew Name: (transliteration)					<input type="checkbox"/> Kohen <input type="checkbox"/> Levi <input type="checkbox"/> Yisroel
Bar/Bat Mitzvah: Parsha:		Haftorah:		Date:	B/M Date:
E-Mail Address:				Cell Phone:	
Jewish Status: <input type="checkbox"/> Born Jewish		<input type="checkbox"/> Converted to Judaism		<input type="checkbox"/> Not Jewish	
Conversion Date:		Place:		Rabbi & Affiliation:	
Relationship to Member 1: <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Other			Relationship to Member 2: <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Other		

Child Number ____

<input type="checkbox"/> Male	<input type="checkbox"/> Female	Date of Birth: Month	Day	Year	<input type="checkbox"/> After Sunset
Name: First		Middle		Last	
Hebrew Name: (transliteration)					<input type="checkbox"/> Kohen <input type="checkbox"/> Levi <input type="checkbox"/> Yisroel
Bar/Bat Mitzvah: Parsha:		Haftorah:		Date:	B/M Date:
E-Mail Address:				Cell Phone:	
Jewish Status: <input type="checkbox"/> Born Jewish		<input type="checkbox"/> Converted to Judaism		<input type="checkbox"/> Not Jewish	
Conversion Date:		Place:		Rabbi & Affiliation:	
Relationship to Member 1: <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Other			Relationship to Member 2: <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Other		

Complete for all Yahrzeit reminder notices

Yahrzeit Reminders

Deceased Name: First			Middle			Last		
Hebrew Name: (transliteration)						<input type="checkbox"/> Kohen <input type="checkbox"/> Levi <input type="checkbox"/> Yisroel		
Yahrzeit: English Date: Month			Day			Year		
<input type="checkbox"/> After Sunset						or Hebrew Date: Day		
						Month		
Observed by: <input type="checkbox"/> Family			<input type="checkbox"/> Member 1			<input type="checkbox"/> Member 2		
Relationship:								
Deceased Name: First			Middle			Last		
Hebrew Name: (transliteration)						<input type="checkbox"/> Kohen <input type="checkbox"/> Levi <input type="checkbox"/> Yisroel		
Yahrzeit: English Date: Month			Day			Year		
<input type="checkbox"/> After Sunset						or Hebrew Date: Day		
						Month		
Observed by: <input type="checkbox"/> Family			<input type="checkbox"/> Member 1			<input type="checkbox"/> Member 2		
Relationship:								
Deceased Name: First			Middle			Last		
Hebrew Name: (transliteration)						<input type="checkbox"/> Kohen <input type="checkbox"/> Levi <input type="checkbox"/> Yisroel		
Yahrzeit: English Date: Month			Day			Year		
<input type="checkbox"/> After Sunset						or Hebrew Date: Day		
						Month		
Observed by: <input type="checkbox"/> Family			<input type="checkbox"/> Member 1			<input type="checkbox"/> Member 2		
Relationship:								
Deceased Name: First			Middle			Last		
Hebrew Name: (transliteration)						<input type="checkbox"/> Kohen <input type="checkbox"/> Levi <input type="checkbox"/> Yisroel		
Yahrzeit: English Date: Month			Day			Year		
<input type="checkbox"/> After Sunset						or Hebrew Date: Day		
						Month		
Observed by: <input type="checkbox"/> Family			<input type="checkbox"/> Member 1			<input type="checkbox"/> Member 2		
Relationship:								
Deceased Name: First			Middle			Last		
Hebrew Name: (transliteration)						<input type="checkbox"/> Kohen <input type="checkbox"/> Levi <input type="checkbox"/> Yisroel		
Yahrzeit: English Date: Month			Day			Year		
<input type="checkbox"/> After Sunset						or Hebrew Date: Day		
						Month		
Observed by: <input type="checkbox"/> Family			<input type="checkbox"/> Member 1			<input type="checkbox"/> Member 2		
Relationship:								
Deceased Name: First			Middle			Last		
Hebrew Name: (transliteration)						<input type="checkbox"/> Kohen <input type="checkbox"/> Levi <input type="checkbox"/> Yisroel		
Yahrzeit: English Date: Month			Day			Year		
<input type="checkbox"/> After Sunset						or Hebrew Date: Day		
						Month		
Observed by: <input type="checkbox"/> Family			<input type="checkbox"/> Member 1			<input type="checkbox"/> Member 2		
Relationship:								