

# NEW YORK STATE ASSOCIATION OF AUXILIARY POLICE, INC.

RESPONDING TO THE NEEDS OF VOLUNTEER LAW ENFORCEMENT

PO Box 351, Massapequa, NY 11758

www.auxiliary-police.org • nysaap@auxiliary-police.org

516-795-4378

## MEMBERSHIP APPLICATION

The New York State Association of Auxiliary Police, Inc. is a type A Not for Profit trade association incorporated in 1973 as the New York State Auxiliary Police Association, Inc. in Dutchess County, NY. In 2001 we re-organized as NYSAAP and we have been representing members of Uniformed Volunteers in Law Enforcement, primarily Auxiliary Police in New York State every since. The primary purpose and objective of the Association is to promote and improve the benefits of its members, promote the understanding and cooperation between members of the Association and of professional Law Enforcement agencies with which they interact, and promote the value of volunteer Law Enforcement programs to the communities they serve.



New Member      Renewal Membership # \_\_\_\_\_

### PLEASE WRITE LEGIBLY OR TYPE

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last Name \_\_\_\_\_

Mailing Address \_\_\_\_\_ Apt. \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Hm Ph (\_\_\_\_) \_\_\_\_\_ Bus Ph (\_\_\_\_) \_\_\_\_\_ Cell Ph (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Occupation \_\_\_\_\_

Email 1 \_\_\_\_\_ Email 2 \_\_\_\_\_

Agency/Precinct or Unit Name \_\_\_\_\_ County \_\_\_\_\_ Region # \_\_\_\_\_

Agency Contact Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Rank \_\_\_\_\_ Shield # \_\_\_\_\_ Years in Service \_\_\_\_\_

### AGREEMENT

I personally read and answered every question fully and honestly.

**Please submit copy of police ID, application, check or money order in the amount of \$15 payable to NYSAAP.**

\_\_\_\_\_  
Signature of applicant

\_\_\_\_\_  
Date

Applications are considered for membership without regard to race, color, religion, sex, national origin, age, marital or veteran status, or the presence of a non-duty-related medical condition or handicap



**DO NOT WRITE IN THE SHADED BOX BELOW. FOR ASSOCIATION USE ONLY.**

Date application rec'd. \_\_\_\_\_

Agency verification \_\_\_\_\_

Payment type \_\_\_\_\_ Amt. \$ \_\_\_\_\_

Check# \_\_\_\_\_ Deposit Date \_\_\_\_\_

\$10.00 Active member

\$1.50 Associate members

\$0.00 Honorary member

\$5.00 Regional dues paid

\_\_\_\_\_ # Membership Cards

\_\_\_\_\_ # Associate Cards

Comments: \_\_\_\_\_

Mailed

Other