



**Register as a Supporter of Single-Payer Health Care:  
Improved Medicare for All**

**PLEASE PRINT IN CAPITAL LETTERS!**

Name \_\_\_\_\_

Email \_\_\_\_\_

Street address \_\_\_\_\_

City \_\_\_\_\_ zip + 4 \_\_\_\_\_

Phone \_\_\_\_\_

Check if you would like to be: A dues-paying member \_\_\_\_\_ Active in the movement \_\_\_\_\_

Name \_\_\_\_\_

Email \_\_\_\_\_

Street address \_\_\_\_\_

City \_\_\_\_\_ zip + 4 \_\_\_\_\_

Phone \_\_\_\_\_

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