National Association of Farmers' Market Nutrition Programs (NAFMNP)

Associate Membership Application

Name: _____

Address: _____

City: _____

State: _____ Zip: _____ County: _____

State agency name: _____

WIC or SR FMNP Coordinating agency: _____

Phone:_____ Email: _____

Website: _____

Send your completed membership application and your check to:
NAFMNP
P. O. Box 9080
Alexandria, Virginia 22304