ALLIANCE OF FORD MOTOR MINORITY DEALERS

Membership Application

Name: ____

Dealership (s): ____

Address: ____

City: __________________**State**: ________________ **Zip Code**: ___________

Additional Dealerships and / or Franchises: ___________________________
____

Contact Information:

Phone Number: ____________________________

Cellular Phone Number: _____________________

Private Fax Number: ________________________

Email Address: ____________________________

(*All contact information will be kept private & confidential, the information will only be used to communicate with our members)*

Please mail the application to:

AFMMD
c/o Osvaldo Garcia Jr.
P.O. Box 66114
Newport, MI 48166-0114

(734) 289-2975