



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