



2024 Allied Member Application

APPLICANT INFORMATION *(Please type or print)*

HEAD OF FIRM (NAME/TITLE)		PHONE	E-MAIL
PRIME CONTACT (NAME/TITLE)		PHONE	E-MAIL
COMPANY			
STREET ADDRESS	CITY	STATE/PROVINCE	ZIP/POSTAL CODE
MAILING ADDRESS (IF DIFFERENT)	CITY	STATE/PROVINCE	ZIP/POSTAL CODE
TELEPHONE		FAX NUMBER	
TOLL FREE # (800)		WEBSITE	

The Company listed above is an Operating Division or Subsidiary of:

COMPANY			
STREET ADDRESS	CITY	STATE/PROVINCE	ZIP/POSTAL CODE
MAILING ADDRESS (IF DIFFERENT)	CITY	STATE/PROVINCE	ZIP/POSTAL CODE
TELEPHONE		FAX NUMBER	
TOLL FREE # (800)		WEBSITE	

COMPANY TYPE

- | | |
|---|--|
| <input type="checkbox"/> Architectural/Engineering/Construction | <input type="checkbox"/> Supply Chain Products/Services |
| <input type="checkbox"/> Communication Systems | <input type="checkbox"/> Transportation Equipment/Services |
| <input type="checkbox"/> Data Collection Systems/Services | <input type="checkbox"/> Transportation Operations |
| <input type="checkbox"/> Financial Services | <input type="checkbox"/> Warehouse Equipment/Services |
| <input type="checkbox"/> Information Technology | <input type="checkbox"/> Warehouse Operations |
| <input type="checkbox"/> Logistics Providers | <input type="checkbox"/> Other _____ |

ANNUAL ALLIED MEMBER DUES - \$5,950

Full amount must accompany application. Make check payable to International Foodservice Distributors Association. Please mail form and payment to: IFDA, P.O. Box 791619, Baltimore, MD 21279-1619.

Please charge my: American Express Visa MasterCard

Card # _____ Exp Date _____

Name of Cardholder (Please Print) _____ CVV _____

Signature _____

E-Mail Credit Card Receipt to _____

If accepted for IFDA Allied Membership, we agree to: 1. abide by the Association bylaws, 2. support its activities, and 3. pay the prescribed dues. This application for IFDA Allied Membership is tendered by:

NAME	TITLE
SIGNATURE	DATE