

**ADDITIONS** 

District Code: 7	2 -		
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CPH Customer #:

PLEASE SEND TO: SD DISTRICT OFFICE

Attn: Lutheran Witness 3501 S Gateway Blvd

Sioux Falls SD 57106-1557

Church Name:	Date:	
Address:	Sent By:	
City, State, Zip:	Phone #:	
Email Address:	Fax #:	
Use this form when sending in additi	ions (new names) only. Print (preferably type) correct nam	ne and address.
Name:	Name:	
Address:	Address:	
City/St/Zip:	City/St/Zip:	
Name:	Name:	
Address:	Address:	
City/St/Zip:	City/St/Zip:	
Name:	Name:	
Address:	Address:	
City/St/Zip:	City/St/Zip:	
Name:	Name:	
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City/St/Zip:	City/St/Zip:	
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City/St/Zip:	City/St/Zip:	