Twig No._____
Active ($2.00)_____
Associate_____
Life ($100.00)_____

MEMBERSHIP APPLICATION
WOMEN'S AUXILIARY
GALION COMMUNITY HOSPITAL

NAME_____DATE_____
(LAST) (FIRST) (MIDDLE INITIAL)
ADDRESS_____

CITY_____STATE_____ZIP_____

E-mail Address_____

HOME PHONE_____WORK PHONE_____

IF PRESENTLY EMPLOYEED, NAME OF FIRM_____

CONTACT IN CASE OF EMERGENCY_____
(NAME)

_____
(RELATIONSHIP) (HOME PHONE) (WORK PHONE)
Please list the names and addresses of two (2) references who are not family members:
1.(Name)_____(Phone No.)_____
(Address)_____

2.(Name)_____(Phone No.)_____
(Address)_____

_____

SIGNATURE_____DATE_____

Please use back if additional space is needed. Mail to the <u>Volunteer Services Office, Galion Community Hospital, 269 Portland Way South, Galion, Ohio 44833</u>

_____

For Office use only:
Date Interviewed_____ Date of Acceptance_____
_____Volunteer Services Coordinator