

AUXILIARY MEMBERSHIP APPLICATION
Eastern Long Island Hospital Auxiliary

DATE: _____

I HEREBY MAKE APPLICATION FOR MEMBERSHIP IN THE Eastern Long Island Hospital Auxiliary. I agree to uphold the purpose, by-laws, and policies of the Auxiliary and the hospital which it serves. I understand that my membership is automatically renewed upon payment of annual dues the first of each calendar year to the Treasurer of a Branch of the Auxiliary. **Check for \$20 individual or \$30 family made to ELIH Auxiliary is attached.**

Name (Print) _____

Signature _____

Spouse's First Name _____

Street/PO Box Address _____

Town/State/Zip _____

Telephone _____ E-mail Address _____

I am interested in the following Auxiliary activities:

Volunteer Service In-hospital in Department _____

Corner Shop _____

Opportunity Shop _____

Auxiliary Fund-Raising _____

Auxiliary Projects and Events _____

Please describe any special skills or interests you have which might relate to Auxiliary activities: i.e. clerical, fund-raising, past Auxiliary or hospital experience:

I can be called upon occasionally to stuff envelopes for the hospital, sell tickets for branch functions, or help with other hospital or branch projects as needed _____

.....
FOR OFFICE USE ONLY
APPLICATION RECEIVED BY _____ **DATE RECEIVED** _____

DATE APPLICATION SENT TO MEMBERSHIP DIVISION CHAIR _____