

# AUXILIARY MEMBERSHIP APPLICATION

Eastern Long Island Hospital Auxiliary

DATE: \_\_\_\_\_ BRANCH: \_\_\_ EE/SI \_\_\_ SOUTHDOLD WEST \_\_\_ TWIGS

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 \$15 made to ELIH Auxiliary is attached.**

Name(Print) \_\_\_\_\_ Signature \_\_\_\_\_

Spouse's First Name \_\_\_\_\_

Street Address \_\_\_\_\_

Post Office Box \_\_\_\_\_

Town/State/Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Email \_\_\_\_\_

**I am interested in the following Auxiliary activities:**

Volunteer Service In-hospital in Department \_\_\_\_\_

Corner Shop \_\_\_\_\_

Opportunity Shop \_\_\_\_\_

Branch Fund Raising \_\_\_\_\_

Branch Projects and Events \_\_\_\_\_

**Please describe any special skills or interests you have which might relate to Auxiliary activities: i.e. COMPUTER SKILLS, 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.** \_\_\_\_\_

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FOR OFFICE USE ONLY

APPLICATION RECEIVED BY \_\_\_\_\_ DATE RECEIVED \_\_\_\_\_

DATE APPLICATION SENT TO BRANCH CHAIR \_\_\_\_\_

Revised 1/2019 iMac

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