

**Missouri Baptist Sullivan Hospital Auxiliary
Membership Form
(Please complete each item)**

Today's date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Contact Phone Number: _____

Email Address: _____

Day and Month of Birthday: _____

How do you wish to receive our Cherry Pink Informer Newsletter?

Email _____ Postal mail _____

Type of Membership: Inactive member _____ Pay yearly dues/receive our newsletter

Active member _____ Pay yearly dues and participate in the organization.

If you chose to be an Active member, how do you want to participate? (check below)

_____ Gift shop Circle date and time of 1st choice and mark with an X 2nd choice

T or Thurs 9-12 1-3 3-6 6-8 M or Wed or Fri 10-1 1-4 4-7 Sat or Sun by request

If you would like to be listed on the gift shop schedule as a replacement for someone to call that can't be at their scheduled shift Check here: _____ Your name and number will be on the schedule.

_____ Blood Drives

_____ Other Areas of the Hospital (when available)

_____ Fundraising

_____ Other _____

New members: Please list two references and contact information for them (phone or email)

Prefer at least one current Auxiliary Member or Hospital Employee

1. _____

2. _____

Return this completed application with \$5 dues to: Missouri Baptist Hospital Auxiliary/Membership
751 Sappington Bridge Road
Sullivan, MO 63080

Or mail to Membership Chairman: Karen Ryan
119 Clonts Road
Sullivan, MO 63080

Copies to:
Duty Schedule
Hours Chairman
Publicaion
Membership Chairman