

Jefferson Healthcare Auxiliary Membership Application:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ E-mail: _____

I have enclosed:

- . Dues: @ \$15 a year
- . Lifetime membership: @ \$150
- . Scholarship donation in the amount of: _____
- . Memorial donation in the name of: _____
- . In the amount of: _____

Optional:

I would like to help with:

__ Gift Shop

__ Historic Homes Tour

__ Other Activities