Membership Application

AUXILIARY

Bayhealth Medical Center – Milford Memorial Hospital

New _ _ Renewal _ _ New Address _ _

Dues for Year: *September 1, 20____ to August 31, 20___*

Name _____

Address _____

_____

Phone _____ Date _____

Email _____

Dues (Single) $5.00 ____ (Family) $10.00 ____ Donation $ _____ Total $_____

Make Checks Payable to: MMH Auxiliary.

Mail Completed Form and Check to:

Auxiliary
Bayhealth Medical Center
Milford Memorial Hospital
P.O. Box 199
Milford, DE 19963

Thank you!