Membership Application

PLEASE PRINT

Date Application Submitted: ______________________

Name: First ______________________Middle _____________Last _____________________________________

Name you would like on your nametag, if different than above: ______________________________________

Daytime phone number: ____________________ Night phone number, if different: ________________________

Mailing Address: ____

City/State/Zip: ____

Email Address, if applicable: ____

Date & Year of Birth: ____

Membership Category (please check one):

- Single one-year membership = $12
- Single two-year membership = $20
- Two one-year memberships, same household only* = $20
- Two two-year memberships, same household only* = $40

Payment Method (please check one):

- Check / Money Order

(Please make check payable to: Skyline Medical Center)

- Cash (Please do not mail cash.)
- Credit Card

Card Name: ______________________________________

Account #: _______________________________________

Expiration Date: __________________________________

Name on Card: ____________________________________

* Name of Second Member at same address, if indicated above:

Name: First______________________Middle ____________ Last ____________________________________

*Name you would like on the second member's nametag, if different than above:

Second member's email address, if applicable: ____

Second member's date & year of birth: ____

Return application to: Skyline Medical Center
Attn: Volunteer Services, 3441 Dickerson Pike, Nashville, TN 37207

STAFF USE ONLY:
Date received: ________________________
Method of payment: ___________________
Letter Mailed: ________________________