Auxiliary of Advocate Good Samaritan Hospital
Friends of the Auxiliary Application

PLEASE PRINT

Name _____ Date_____
Last First

Address _____
Street City State Zip Code

Dues: Life $100 ___ Regular $10 ___ Senior $5 ____ (age 65 and over)

Signature of Applicant _____

I would also like to volunteer, please contact me for additional details: Yes ____ No ____

Phone _____

My spouse/family member also wants to become a member:

Name _____

Address (Optional) _____

My spouse/family member would like to volunteer. Please call #_____

I/we would like to be listed in the Auxiliary Membership Directory: Yes ____ No ____

I/we would like to receive mailings, including the Auxiliary newsletter: Yes ____ No ____

Please make check payable to: Auxiliary of Advocate Good Samaritan Hospital and attach it to this application. Mail to: Membership Chairperson, Auxiliary of Advocate Good Samaritan Hospital, 3815 Highland Avenue, Downers Grove, IL 60515

Office Use Only: Date Application Processed _____ Membership Type _____
Dues: Cash $_____Check $_____Check #_____Processed By_____
Date Letter Mailed _____Date Directory Updated _____
Revised 1/15