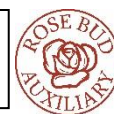


**Rose Bud Auxiliary
Membership Application**



Date _____

Applicant Information

Name/Names: _____

Address: _____

City _____ State _____ Zip _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Please Check Here If We Have Your Permission To Send Auxiliary Communications To You Via Email. Your email will never be shared.

Membership

Membership Donation \$50.00 per person for 2020 (Cash, Checks, and Credit Cards accepted)

Visa – Mastercard – American Express

Card No. _____ Exp. _____ CVV2 _____

Name as it appears on your card: _____ Signature: _____

_____ Date: _____

Billing Address of credit card (if different than above): _____

_____ City: _____ State: _____ Zip: _____

Amount: _____

Make Checks Payable to: **St. Rose Dominican Health Foundation**

Mail Application and Check to: Sherry Eischen
2803 Scotts Valley Drive
Henderson, NV 89052

Volunteer Interests

If you would like to volunteer to be on a committee, please indicate below. Volunteering for a committee is not a requirement to join the auxiliary.

- | | |
|--|--|
| <input type="checkbox"/> Special Events Committee | <input type="checkbox"/> Annual Membership Committee |
| <input type="checkbox"/> Communications / Public Relations Committee | <input type="checkbox"/> Raffle Committee |

Signature/Signatures: _____

I don't wish to join but would like to donate \$ _____

How did you hear about us, member, ad, etc. _____

For questions email Sherry Eischen at rosebudauxiliary.sherry@gmail.com

*Contributions to the St. Rose Dominican Health Foundation may be tax deductible pursuant to the provision of section 170 (c) of the Internal Revenue Code of 1986, 26 U.S.C. 170 (c). Tax ID Number: 88-0349432 RBA Rev. 1/21/20
All membership information is confidential, and will only be used for communicating news, fundraising/event information and volunteer opportunities.*