

Rose Bud Auxiliary Membership Application



Date: _____

Applicant Information

Name: _____ Nickname: _____ Birthday (mm/dd): _____

Mail Address: _____

City, ST: _____ ZIP: _____

Home Address: _____

City, ST: _____ ZIP: _____

What Residential Community Do You Live In? : _____

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

Annual Membership Donation (\$25.00)

Charter Membership Donation (\$50.00) For 2019 only, those who join at this level will receive special recognition on a plaque displayed at St. Rose Dominican Hospital.

Make Checks Payable To: **St. Rose Dominican Health Foundation**
Mail Checks 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.

Special Events Committee
 Communications / Public Relations Committee
 Decorations Committee
 Annual Membership Committee
 Raffle Committee

Special Skills or Interests

Fundraising
 Public Speaking
 Programs
 Marketing
 Microsoft Excel / PowerPoint
 Strategic Planning

Signature: _____

Thank you for your tax deductible contribution!

All membership information is confidential, and will only be used for communicating news, fundraising/event information and volunteer opportunities.

For Office Use Only: Donation Amount: _____ Date: _____ Database Entry: _____