For Office Use Only
Name
Accepted

Alumnae Association of
Hartford Hospital School of Nursing

APPLICATION FORM FOR MEMBERSHIP and ALUMNAE MEDICAL FUND

Date:_____

Name:
Last _____Maiden_____First_____

Address_____

E-mail Address_____

Date of Graduation _____ CT. Reg. No. _____

I wish to apply for reinstatement of membership and enclose the yearly fee of $10.00 which also includes membership in the Alumnae Medical Fund.

Signed:_____

Application form is to be filled out and returned with fee to:

Membership Committee
Alumnae Association of the H.H.S.N., Inc.
560 Hudson Street
Hartford, CT 06106

Checks may be made payable to Alumnae Association of the Hartford Hospital School of Nursing, Inc.