

For Office Use Only

Name

Accepted



**Alumnae Association of  
Hartford Hospital School of Nursing**

**APPLICATION FORM FOR  
ALUMNAE BED FUND MEMBERSHIP**

Date: \_\_\_\_\_

Name:

Last \_\_\_\_\_ Maiden \_\_\_\_\_ First \_\_\_\_\_

Address \_\_\_\_\_

E-mail Address \_\_\_\_\_

Date of Graduation \_\_\_\_\_ CT. Reg. No. \_\_\_\_\_

**I wish to apply for the Alumnae Bed Fund membership and enclose the ONE TIME  
fee of \$50.**

**Signed:** \_\_\_\_\_

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

**Membership Committee  
Alumnae Association of the Hartford Hospital School of Nursing, Inc.  
560 Hudson Street  
Hartford, CT 06106**

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