

For Office Use Only

Name

Accepted



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

**APPLICATION FORM FOR
MEMBERSHIP and ALUMNAE BED 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 Bed 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.