



**Mary Rutan
Hospital**

Auxillary Guild I
Membership Application

Name: _____ Date of Birth: _____
(first, middle, last)

Street Address _____

City, State & Zip _____

Referred by : _____

Please list 1 current Guild Member as a reference OR 3 character references if Guild Member is not known.

1. _____
(name & phone number)

2. _____

3. _____

Why are you interested in volunteering at Mary Rutan Hospital?

Give a brief description of yourself, such as your hobbies, work, or volunteer work you might have done.

I am interested in volunteering:

Morning ___ Afternoon ___ Evening ___ Weekends ___ Anytime ___

Signature _____ Date: _____

Please return application to: Mary Rutan Hospital
205 Palmer Avenue Bellefontaine, OH 43311
Attn: Tammy Allison, Director of Public Relations