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## Partners of MMH&C Membership Form

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Thank you for your interest! Please complete this form and mail it with your **\$5 dues** to Partners of MMH&C, PO Box 40, Friendship, WI, 53934. (*Make checks payable to Partners of MMH&C*). For questions, call the Hospital Gift Shop at (608) 339-3331, extension 301.

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

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Birth Date (month/day) \_\_\_\_\_

If employed, do we have your permission to call you at work? If yes, please list employer name and phone number: \_\_\_\_\_

Hobbies or Special Skills: \_\_\_\_\_

Volunteer Interests (refer to opportunities listed on website)

Days You Are Available:

Mon. \_\_\_\_\_ Wed. \_\_\_\_\_ Fri. \_\_\_\_\_ Sun. \_\_\_\_\_

Tues. \_\_\_\_\_ Thurs \_\_\_\_\_ Sat. \_\_\_\_\_

Personal Reference (name/address)

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