MEMBERSHIP APPLICATION

Today's Date: __________ Referred By: __________

ST. JOSEPH HOSPITAL		✸ New ✸ Renewal
Last Name	**Middle I.**	✸ Mrs. ✸ Ms. ✸ Mr. ✸ Dr.
First Name	**Sex** ✸ M ✸ F	
Phone Number ( )	**Birthday** Mo.____ Day____ Yr.____	
Address	**Apt #**	
City	**State**	**Zip**
E-mail		

I authorize ✸   do not authorize ✸

that a Senior Circle representative may be notified of my admittance to participating hospitals and may contact me while in the hospital to ensure my needs are being met.

Signature ___________________________

Complete the section below only if you are applying for a second member in the same household.

Last Name	**Middle I.**	✸ Mrs. ✸ Ms. ✸ Mr. ✸ Dr.
First Name	**Sex** ✸ M ✸ F	
Phone Number ( )	**Birthday** Mo.____ Day____ Yr.____	
E-mail		

I authorize ✸   do not authorize ✸

that a Senior Circle representative may be notified of my admittance to participating hospitals and may contact me while in the hospital to ensure my needs are being met.

Signature ___________________________

Check one:

✸ One Year Membership $15.00 (SC1)

✸ Two - One Year Memberships $27.00 (TW1)

✸ Two Year Membership $27.00 (SC2)

(you save 10% compared to a one year membership)

Make checks payable to **Senior Circle**. Mail completed application and payment to: **St. Joseph Hospital, ATTN: Senior Circle, 700 Broadway, Fort Wayne, IN 46802**