

# TAHV APPLICATION FOR MEMBERSHIP

Auxiliary/Volunteer Group Name and Address \_\_\_\_\_

\_\_\_\_\_

Hospital Name and Address \_\_\_\_\_

\_\_\_\_\_

DVS/Volunteer Coordinator \_\_\_\_\_

DVS/Volunteer Coordinator Phone Number \_\_\_\_\_

DVS/Volunteer Coordinator Email Address \_\_\_\_\_

Auxiliary/Volunteer Group President Name and Address \_\_\_\_\_

\_\_\_\_\_

Total Volunteer Membership \_\_\_\_\_

**Membership Dues:**

*(Dues Determined by Hospital Bed Size)*

*(Dues payable June 1 - delinquent October 1)*

_____	1 to 75 Beds	\$35.00
_____	76 to 140 Beds	\$50.00
_____	141 to 250 Beds	\$75.00
_____	251 to 399 Beds	\$100.00
_____	400 +	\$150.00
_____	No bed institution	\$30.00

\_\_\_\_\_

Date Volunteer Group Organized

\_\_\_\_\_

Signature of Volunteer Coordinator

\_\_\_\_\_

Date of Application

\_\_\_\_\_

Signature of Hospital Administrator

Please return to:

Jo Ann Goodwin  
213 Crescent Drive  
Early, TX 76802

