Partners of The Richland Hospital & Clinics
Membership Application



New Member:
☐ YES, I would like to join Partners of The Richland Hospital & Clinics. Enclosed is my $10.00 membership fee for the current year.

Renewal:
☐ YES, I would like to renew my membership.
☐ Enclosed is my $10.00 membership fee for _____ (please indicate current year)

Lifetime:

- ☐ YES, I would like to become a lifetime member. Enclosed is my $100 membership fee

Name: _____

Address: _____

_____

Preferred Telephone # _____

If mobile phone, can we text? ◯ Y ◯ N

Email Address: _____

Preferred method of communication:

◯ phone ◯ email ◯ text

◯ US Mail

Please check all areas in which you would be interested in volunteering:

☐ Baking
☐ Sale events
☐ Lobby Shoppe staffing
☐ Assisting at Special Events
☐ Information Desk
☐ Making Phone Calls
☐ Advocacy
☐ Preparing mailings

Please share about what you would like to hear at the Quarterly meetings in April, July and October:

_____
_____
_____
_____

Please submit application and membership fee to:

Sarah Stibbe, Adm. Assistant and Volunteer Coordinator
The Richland Hospital & Clinics
333 East Second Street
Richland Center, WI 53581