

Miami Children's Hospital Alumni Association Membership Application 2011-2012



Name: _____

Specialty: _____

MCH Medical Staff Member Yes ___ No ___

Date of Birth _____ Graduation Year _____

Office Address _____

Office Telephone Number: _____ Office Fax Number: _____

E-Mail _____

Home Address: _____

Home Telephone Number: _____ Home Fax Number: _____

Membership Fees

- Alumni \$125
- Non Alumni MCH Faculty Individual Membership \$150
- Non Alumni MCH Faculty Group Membership of 4 or more \$400

If paying by Credit Card, please fax completed form to 305 669-6406

I authorize Miami Children's Hospital to charge \$_____ to the following credit card

Please circle card type: Visa Master Card American Express Discover

Card Number: _____ Exp Date: _____

Card Holder Signature: _____

If paying by check please make check payable to:
Miami Children's Hospital Alumni Association
return it along with the completed application to:

Miami Children's Hospital Alumni Association
3100 SW 62nd Avenue
Miami, Florida 33155

Telephone Number: 1 800 445-9340 Facsimile Number: 305 669-6406