

# Orange County Circle of Friends 2010 Membership Enrollment Form

To join HB Chapter Mail or Bring to: 17772 Beach Boulevard, Huntington Beach, CA 92647  
(Beach Boulevard at Newman, Lower Level of Hospital) - Telephone: (714) 843-5061

or

To join WA Chapter Mail or Bring to: 3033 West Orange Avenue, Anaheim, CA 92804  
Beach Boulevard at Orange Avenue. 1st Floor - West Anaheim Medical Center

**For Single Membership:**  New  Renewal  Huntington Beach Hospital Chapter  West Anaheim Medical Center Chapter

**Member 1:**

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

Mailing Address \_\_\_\_\_ Apt/Space # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Telephone (\_\_\_\_\_) \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Gender:  Male  Female

E-mail Address \_\_\_\_\_

First name desired on membership badge \_\_\_\_\_

Emergency Contact: Name \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone (\_\_\_\_\_) \_\_\_\_\_

Are you interested in volunteering?  Yes  No

How did you hear about us? \_\_\_\_\_

### Signature Required Below

**For Dual Membership:** (must be at same address as member above)  New  Renewal

**Member 2:**

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Gender:  Male  Female

E-mail Address \_\_\_\_\_ Telephone (\_\_\_\_\_) \_\_\_\_\_

First name desired on membership badge \_\_\_\_\_

Emergency Contact: Name \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone (\_\_\_\_\_) \_\_\_\_\_

Are you interested in volunteering?  Yes  No

How did you hear about us? \_\_\_\_\_

**Single Membership**  One-year \$20  Two-year \$35

**Dual Membership** (members must be at the same address)  Two 1-year memberships \$35  Two 2-year memberships \$60

**Gift Membership**  One year \$20.00 Given by: \_\_\_\_\_

Enrollment processing and receipt of membership materials may take 4-6 weeks. Membership is non-refundable and non-transferable. Circle of Friends reserves the right to cancel any event, offer, or membership. In exchange for participating in a Circle of Friends Event, I release West Anaheim Medical Center, La Palma Intercommunity Hospital, Huntington Beach Hospital, Garden Grove Hospital and their Circle of Friends Chapters of all liabilities, which I may have against them in any way connected with my participation in the Event. Additionally, I allow permission for, and authorize the use of, my name, photograph, voice, or quotes, to be used for promotions by any of the above parties.

\_\_\_\_\_  
Signature (Required)

(Office use only)

Date Processed \_\_\_\_\_

Initials \_\_\_\_\_

\_\_\_\_\_  
Signature if dual membership (Required)

(Office use only)

Date Recv'd \_\_\_\_\_

Initials \_\_\_\_\_