

**APPLICATION FOR TAHV MEMBERSHIP**

**Auxiliary/Volunteer Group Name and Address**

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**Hospital Name and Address**

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**DVS/Volunteer Coordinator Name and Contact information**

Name \_\_\_\_\_

Phone number \_\_\_\_\_

Email \_\_\_\_\_

**Auxiliary/Volunteer Group President Name and contact information**

Name \_\_\_\_\_

Address \_\_\_\_\_

Email \_\_\_\_\_

Total volunteer membership: \_\_\_\_\_

**Membership Dues are determined by hospital bed size.**

**Dues are payable by June 1<sup>st</sup> and delinquent by October 1<sup>st</sup>.**

_____ 1-75 beds	\$ 35.00
_____ 76-140 beds	\$ 50.00
_____ 141-250 beds	\$ 75.00
_____ 251-399 beds	\$100.00
_____ 400+ beds	\$150.00
_____ No Bed Institution	\$ 35.00

**Return to:**

**Lynda Demasco  
27 Antelope Trail  
Kerrville, TX 78028**

