Membership Application

Name(s) _____
Street Address _____
City _____
State _____
Zip _____

Telephone (Home) _____
Telephone (Work) _____

_____ Annual Membership $25.00
_____ Life Membership $150.00
_____ Donation

Please enclose a personal check, made payable to University Hospital Auxiliary,

in the amount of $_____ and Mail to:

University Hospital Auxiliary
7020 SUNY
Level 2, Room 617
Stony Brook, NY 11794-7020
Office Telephone: 631-444-2699