



SAN FRANCISCO AUXILIARY FOR CHILDREN

benefiting Lucile Packard Children's Hospital at Stanford

Application for Membership

NAME _____ MAIDEN NAME _____

DATE OF BIRTH _____ BIRTH PLACE _____

RESIDENCE _____ CITY _____ STATE _____ ZIP _____

PHONE _____ CELL _____ E-MAIL ADDRESS _____

NAME TO BE USED IN ROSTER _____

JOB TITLE OR OCCUPATION _____

FIRM NAME _____ BUSINESS ADDRESS _____

CITY _____ ZIP _____ BUSINESS PHONE _____

OTHER BUSINESS EXPERIENCE _____

EDUCATION: HIGH SCHOOL _____ YEAR GRADUATED _____

COLLEGE _____ YEAR GRADUATED _____

ACTIVITIES AND OFFICES _____

TALENTS ,HOBBIES, SPECIAL INTERESTS: _____

HUSBAND'S NAME: _____

JOB TITLE OR OCCUPATION _____

FIRM NAME, ADDRESS _____

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Sponsors Notes

HOW LONG HAVE YOU KNOWN THE APPLICANT _____

REMARKS _____