

Bedford Medical Center Senior Network Membership Application

Name: _____ **Date Applied:** _____

Company Name: _____ **Title/Position:** _____

Address: _____

City / State / Zip: _____

Business Phone: _____ **Cell Phone:** _____

E-Mail: _____

Description of Business: _____

Participation:

Active involvement in at least one committee, event donor contribution and attendance at six membership meetings is required each year.

Attach completed Committee Sign Up sheet to this application and return to:

Cilla Buck
Membership Chair
9993 Colmanara Drive
Reminderville, OH 44202
Fax: 440.201.6950 ***Email: cilla.buck@carepatrol.com***

Membership is subject to approval of the Board.