APPLICATION FORM FOR AUXILIARY

"HOME"

HOSPITAL VOLUNTEER PINS

Submitted by: _____
(Aux. Hospital Chairman or President & Aux. Name and Number)

Send Pins to: Name _____

Address_____

City _____Zip_____

List Auxiliary members and their Auxiliary Number who are entitled to "HOME" Hospital Volunteer Pins who have accumulated 75 hours or more by sewing, cooking, etc., at home For patients in VA, State, Military Hospitals or Veteran Approved Nursing Homes.

NAME	**AUXILIARY CARD NO.**

Send to:

Georgia Watson, Dept. Hospital Chairman
7745 Nottingham Ct. SE
Olympia WA 98503-1909
Phone: (360) 915-6477
E-mail: nrgwats@comcast.net

Approved _____
Date _____