



# College of Health Professions Alumni Association Membership Form

Discovering. Understanding. Healing.

-----**Personal Information**-----

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Maiden Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (    ) \_\_\_\_\_

-----**Business Information**-----

Current Employer: \_\_\_\_\_

Type of Business: \_\_\_\_\_

Position/Title: \_\_\_\_\_

Business Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Business Phone: (    ) \_\_\_\_\_

-----**Other Information**-----

E-mail address: \_\_\_\_\_

CHP Degree: \_\_\_\_\_ Class Year: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

I would be interested in volunteering for the alumni association.

Send correspondences to:     Home         Business

-----**Dues Information**-----

Please select one of the following:

I would like to support my College through annual dues of \$25.00 to the College of Health Professions Alumni Association.

I would like to support my College, through a Life Membership of \$200 to the College of Health Professions Alumni Association.

Payment method:

Check         Credit Card [  MasterCard OR  Visa ]  
Card #: \_\_\_\_\_ Exp. Date: \_\_\_\_\_  
Signature: \_\_\_\_\_

Return this form to: MUSC Alumni Affairs 268 Calhoun St. Charleston, SC 29425

**THANK YOU FOR YOUR CONTINUED SUPPORT!**