



Nina B. Hollis Wellness Center Alumni Membership Form

Individual Annual \$150 3 Mos. \$37.50 6 Mos. \$75.00

Family Annual \$250 3 Mos. \$62.50 6 Mos. \$125.00

How did you hear about this benefit? _____

Date and Time of app.: _____ New Renewal

Alumni Name: _____ DOB: _____ ID# _____ Yr. Grad _____

Home Address: _____

City: _____ Zip: _____ e-mail _____

Home Phone: _____ Cell Phone: _____

For a Family Membership:

Spouse's Name: _____ DOB: _____ ID# _____

Children age 16 or older: (Children 15 and under limited to pool usage only)

Name: _____ Birth date: _____ ID# _____

Name: _____ Birth date: _____ ID# _____

Additional Family Member (\$25 each):

Name: _____ Relation: _____ Birth date (if child): _____ ID# _____

Emergency Contact:

Name: _____ Relation: _____ Phone: _____

I declare that I have read and understood the policies and information provided within this packet and that the above named persons are members of my immediate family, currently residing full-time in my home and the address listed above is their only place of residence.

Alumni Signature: _____ Date: _____

Office Use Only

Staff: _____ Total Paid: _____ Date Paid: _____

Cash Check MasterCard Visa

Scanned to Advancement