



**SENIOR  
HEALTH ALLIANCE**

**Galichia Heart  
HOSPITAL**

*Providing optimal service  
with utmost care*

## MEMBERSHIP APPLICATION

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

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

**Telephone:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Spouse Name:** \_\_\_\_\_

**E-mail:** \_\_\_\_\_

**Care Giver Information (if one is needed):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Emergency Contact Information (Name, Address, Phone Number, Etc...):**

\_\_\_\_\_  
\_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**FOR OFFICE USE ONLY**

Member I.D. #: \_\_\_\_\_ Liaison: \_\_\_\_\_