BROADLAWNS MEDICAL CENTER **GUILD**

❑ **YES! I would like to become a member of the Broadlawns Medical Center Guild.**

Name: _____

Address: _____ **City, State, Zip:** _____

Phone Number: _____ **Email Address:** _____

I would like to support the Guild in the way of:

❑ **One-year Membership** ($5)

❑ **Lifetime Membership** ($100)

❑ **Donation to the Guild $**_____

All payments must be made in full. My payment is enclosed in the form of:

❑ **Cash**

❑ **Check** *Please make payable to Broadlawns Medical Center Guild*

❑ **I am interested in volunteering for the Guild, please notify me about upcoming volunteer opportunities.**

Signature: _____ **Date:** _____

Please send your completed form and payment to:
Broadlawns Medical Center Guild
Attn: Mark Jacobs
1801 Hickman Road
Des Moines, IA 50314

For Office Use Only

Date Received: _____

Total Amount Received: _____

❑ **Cash** ❑ **Check** ❑ **BMC Payroll Deduct**