UF MEDICAL GUILD MEMBERSHIP FORM
Celebrating Friendship, Fun, and Philanthropy Since 1959

1. Complete the form below. If you are renewing your membership and no information has changed, fill in the Date, indicate Type: “Renew: No Changes”, and your Name on the form. Going forward, we are encouraging Guild members to note their present or past occupation. If you are a new member or there are changes to any information, please note them on the form.

2. Membership is from May 1st through April 30th. Dues are payable on May 1st. Please include a check for your dues ($50/year) payable to UF Medical Guild.

3. Please mail your form and check (if applicable) to:
   UF Medical Guild Membership; JHMHC Box 100215; Gainesville, FL 32610-0215

Date of application: __________ Type: ___New ___ Renew ___Renew: No Changes

Referred by: ____________________________________________________________

Name:  
Title: ___ ___  First: ________________  Last: ____________________________

Phone: Home: ____________________  Cell: ________________

Address: Street: ____________________

City: _____________  ST: ___ ___  ZIP: ________________

Subdivision (if local): __________________________

Member’s Present/Past Occupation: ________________________________

Email Address: ________________________________

Birth month/day: ___ / ______

Spouse/Partner: Name: ________________________________

___ Working  ___ Retired  ___ Deceased

By submitting this application, you are agreeing to support our mission statement which is to promote friendship among the members and to provide philanthropic support to UF Health and the communities it serves.

_______________________________________________

For office use only: Date received: __________ posted: __________