



## UF MEDICAL GUILD MEMBERSHIP FORM

*Celebrating Friendship, Fun, and Philanthropy Since 1959*

Revised Feb 2024

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. If there are changes to any information, please note them on this form.
2. If you are a new member, then your membership fee is waived during your first year.
3. Membership is from May 1st through April 30th. Dues are payable on May 1st. Please include a check for dues of \$75 payable to **UF Medical Guild**.
4. Please mail this form and check (if applicable) to:

***UF Medical Guild Membership, P.O. Box 142246, Gainesville, FL 32614***

**Date of application:** \_\_\_\_\_ **Type:** ☐ New ☐ Renew ☐ Renew: No Changes

**Referred by:** \_\_\_\_\_

**Name:**

*Title:* \_\_\_\_\_ *First:* \_\_\_\_\_ *Last:* \_\_\_\_\_

**Phone:** *Landline:* \_\_\_\_\_ *Cell:* \_\_\_\_\_

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

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

*Subdivision (if local):* \_\_\_\_\_

**Present or 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: \_\_\_\_\_