



**LIFEPATH**  
H O S P I C E

A Chapters Health® Affiliate

**Hospice Women of Philanthropy  
Membership Application**

Date: \_\_\_\_\_

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

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

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

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

Birth Month: \_\_\_\_\_ Day: \_\_\_\_\_

Communication Preference:  Phone  E-mail  Regular Mail

Specific Hospice Experience or History: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Your interest in serving on Hospice Women of Philanthropy Committees:

Membership  Yes  No      Education  Yes  No

Project Review  Yes  No

May we publish your name?  Yes  No

**I wish to join and make my annual tax-deductible contribution of \$500.**

Check enclosed made payable to: LifePath Hospice

Please bill me

Charge my annual contribution to (check one):

Visa  MasterCard  Discover  American Express

Cardholder's Name (please print) \_\_\_\_\_

Card Number \_\_\_\_\_

Expiration Date \_\_\_\_\_

Signature \_\_\_\_\_

**Your Annual contribution is due by December 31st.**

Please mail this application along with your annual tax-deductible contribution to:

LifePath Hospice  
12470 Telecom Drive, Suite 410 East  
Temple Terrace, FL 33637  
(813) 871-8011  
www.chaptershealth.org