Alumni Association of Bethesda School of Nursing
Membership

Name:____

Address:____

City:_____________________**State:**_____**Zip:**_______**Phone number:**__________

Graduation Year:________**Last name at time of graduation:**____________________

Alumni Association membership fee — ***$15.***

Enclosed is a donation to the alumni association. Amount:_________

Send this form along with your dues to: Alumni Association of Bethesda School of Nursing, The Bethesda Foundation, 10500 Montgomery Road, Cincinnati OH 45242.

Make checks payable to the Alumni Association of Bethesda School of Nursing. No receipt or membership card will be returned. Your cancelled check will be your receipt.