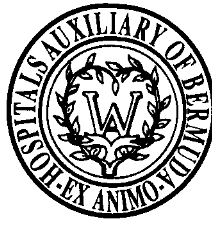

THE HOSPITALS AUXILIARY OF BERMUDA
P.O. Box HM 1023, Hamilton, HMDX, Bermuda
Telephone: (441) 236-2488   Facsimile: (441) 236-4256
email: hab.secretary@bhb.bm or jane.wright@bhb.bm

CANDY STRIPER APPLICATION FORM

Date of Application ______________________ Date of Birth ______________________
Day Month Year / Day Month Year

Name Miss/Mr. ____ Age _______
Surname First Middle

Mailing Address ____

Home Phone ___________________________ Student's E-Mail Address: __________________________

Mother's Name __________________________________ Mother's Business Phone # _________________

Father's Name ___________________________________ Father's Business Phone # __________________

Guardian's Name _________________________________ Guardian's Business Phone # ________________

School Attending ____ Year ________________

Principal ____ School Phone # ________________

School Guidance Counselor ___________________________________

Volunteer Work (past and present) ____

____

Organizations/Clubs/Churches/etc. of which you are a member (past and present)_________________________

____

Employment (past and present, part time or full time) ____

Please list name(s) of any siblings in the Programme or parents employed by the BHB ___________________

Applicant's Signature ____

For Office Use Only:
Date Received____________ Date Acknowledged____________ Year of Eligibility ____________