THE HOSPITALS AUXILIARY OF BERMUDA
P.O. Box HM 1023, Hamilton, HMDX, Bermuda
Telephone: (441) 236-2488 Facsimile: (441) 236-4256
email: 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 _____

Bermuda Registered Charity #14