Morton Plant Mease
Health Care Foundation

PLANNED GIVING ADVISORY COUNCIL

Membership Application

Purpose: To increase awareness and support of Morton Plant Mease Health Care Foundation's mission and the hospitals it serves through education and collaboration of advisory members in legacy planning.

Full Name: **Date:**

Nickname: **Birthdate:**

Home Address:

Cell Phone: **Home Phone:**

Business Name:

Business Address:

Business Phone: **Fax:**

E-Mail Address:

Business Title:

Business Specialty:

Professional Certifications or Licenses:

Educational Background:

Civic Activities:

Donor Society you would like to join:

How did you hear about us?

Please return the completed application to Michele Schneidenbach, Director of Development
Mail: 1200 Druid Road S, Clearwater, FL 33756 | Fax: (727) 461-8131 | Email: Michele.Schneidenbach@BayCare.org

Morton Plant Mease
Health Care Foundation

Hospitality Services
Permission for Notification of Hospital Admission
Confidential

_____ I/We give permission to the Morton Plant Mease Health Care Foundation to flag my/our electronic medical record as a Foundation member. I/We understand that the flag will alert hospital staff to notify Foundation personnel that I/we have been admitted to the hospital. I/We understand Foundation may notify hospital staff of my/our admission and my/our Foundation donor status.

_____ I/We wish to decline this benefit.

The information provided to the Foundation will only include my demographic information (including name, address, and date of birth) and location. It will not contain specific medical information.

My Information

Patient Name _____ Date of Birth _____

Address _____
City State Zip

Home Phone: _____ Cell Phone: _____ Email: _____

Religious Affiliation: _____ Place of Worship: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Spouse Information

Spouse's Name: _____ Date of Birth: _____

Cell Phone: _____ Email: _____

Religious Affiliation: _____ Place of Worship: _____

Employment

Employer: _____ Phone: _____ Email: _____

Address: _____
City State Zip

Minor Children (under 18)

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Signatures (required for each adult listed)

_____ Date: _____
Signature

_____ Date: _____
Spouse's Signature

Please remember to bring your most current insurance information at the time of your Hospital admission along with a list of current medications, Advance Directive and Health Care Surrogate information