

WOOSTER COMMUNITY HOSPITAL'S SENIOR PARTNERS PROGRAM APPLICATION

To enjoy the benefits of this program, simply complete the application and return it to: **Wooster Community Hospital**
Senior Partners Office
1761 Beall Avenue
Wooster, Ohio 44691

(Please Print)

Name _____

Date of Birth _____

Mailing Address _____

City _____ **State** _____ **Zip Code** _____

Telephone Number _____ **Physician** _____

Spouse's Name _____

Date of Birth _____ **Physician** _____

Email Address _____

Would you like to have the quarterly Senior Partners' Newsletter emailed to you?

Yes **No**

(Office Use Only)

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