

**Alumnae Association II
Of
The Bridgeport Hospital School of Nursing**

**Application Form for Membership
Endowed Bed**

Date _____

Name _____
Last _____ (Maiden) _____ First _____

Address _____ Tel. _____

City _____ State _____ Zip _____

Email _____

Date of Graduation _____

Are you a member of BHSN Alumnae Association I _____ (yes) _____ (No)

Annual Dues: \$15
(Next billing date October 2026)

**This application is to be filled out with the necessary fee, paid to AAll BHSN, and return to the Secretary: Helen Pappano, 203-521-8691,
helenpappano@sbcglobal.net**

**Helen Pappano, AAll Secretary
105 Brookfield Rd
Seymour, Ct 06483**

Current Membership in the Bridgeport Hospital School of Nursing Alumnae Association I is required.