# Deaconess Hospital School of Nursing Alumni Fund Request

Name:_____ Graduating Class:_____

Current Address:_____

City _____ State_____ Zip_____

Member of DHSON Alumni Association? _____

Request Amount:_____
Attach receipts, copy of registration, etc.

Purpose of Request:_____

_____

_____

_____

_____

Request Granted: ☐ Yes ☐ No

Date: _____

_____ _____
Signature: DHSON Board Member Title, DHSON Board

For request grants of greater than $250, signature of two Board members is required.

_____ _____
Signature: DHSON Board Member Title, DHSON Board