

OASIS
MEMBERSHIP FORM

Please print legibly to help ensure that all information provided is accurate. Information shall be used for Oasis business only.

Name (Last, First, Middle Initial) _____

Nickname _____ Male____ Female____

Street Address _____ Apt/Unit No. _____

City _____ State _____ Zip Code _____

Previous City/State (optional) _____

Home Phone _____ Mobile Phone _____

Email Address _____ Birthday (No year!) _____

Staff Member Spouse's/Partner's Name
_____ Dept. _____

What new activities are you interested in? _____

Are you willing to chair an activity? Yes ____ No ____ Maybe ____

Would you be interested in serving on the Executive Board? Yes ____ No ____ Maybe ____

Renewal ____ New Member ____ Change to contact information ____

Are you interested in being on a Mayo Clinic-maintained e-mail distribution list to learn of Mayo-sponsored and/or -affiliated events and opportunities? Yes ____ No ____

As an Oasis member, I agree to limit the use of Oasis member contact information to the purposes of the organization.

Signature _____ Date _____

PLEASE RETURN THIS FORM TO:

MCA Oasis Group
C/O Karen L. Nick
PX_SS_01_HR
Mayo Clinic
5777 E Mayo BLVD
Phoenix, AZ 85054