Jefferson
Thomas Jefferson University
HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

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CAMPAIGN

APPLICATION FOR RELIEF TRUST FUND BENEFITS

To Be Eligible for Relief Fund Benefits

1. Membership in the Diploma Nurses' Alumni Association for one year preferred. However, all requests will be given consideration. All things being equal, members will be given first consideration.

The Following Are Entirely Excluded:

1. Pregnancy and its complications
2. Cosmetic surgery
3. Dental surgery and/or complications

How to Apply for Relief Fund Benefits

1. Complete your part (the top portion) of the Benefit Form and sign the authorization at the bottom.

2. Have your physician complete his or her part of the Benefit Form.

3. If the Alumni member cannot complete the Benefit Form, the person submitting the form must include his or her relationship to the member when signing and give their address and telephone number.

4. The completed Benefit Form should be sent to:

Chairman, Relief Trust Fund Committee
Jefferson Diploma Nurses' Alumnni Association
Pinizzotto-Ammon Alumni Center
Jefferson Alumni Hall
1020 Locust Street, Suite 210
Philadelphia, PA 19107-5233

All information remains confidential.

All Relief Trust Fund requests are considered by the Board of Directors of the Nurses' Alumni Association for the amount of monies granted.

APPLICATION FOR RELIEF TRUST FUND BENEFITS

Nurses' Alumni Association
School of Nursing (Diploma Program)
Thomas Jefferson University
College of Health Professions
215-955-8981

Applicant Data

1. Name: ____
(Last Name) (First Name) (Middle Initial) (Maiden Name)

2. Address: ____
(Number and Street) (City) (State)

3. Year of Graduation: __________ Social Security #: ______________ Telephone #: ______________

Type of Membership: ❑ Life ❑ Active

Have you received Alumni Benefits before? ❑ No ❑ Yes, Date: ______________

List your specific needs: ______________________________

Include the reason for this specific request: ______________________________

Signature: ______________________________
❑ Applicant ❑ Representative

Relationship to applicant: ______________________________

Attending Physician Statement

Patient's Name: ______________________________

Diagnosis (If injury, give date of accident): ______________________________

Date first consulted for this illness: ______________ Length of illness: ______________

If patient hospitalized: Name of Hospital: ______________ Dates: ______________

If patient in nursing home or extended care facility:

Name of Facility: ______________________________

Address of Facility: ______________________________

Physician's Signature: ______________________________ Degree: __________

Address: ______________________________
(Number and Street) (City) (State)

Authorization

I herby authorize the above named physician to release any and all information requested by the Jefferson's Nurses' Alumni Association with respect to this claim for Relief Fund Benefits.

Signature: ______________________________ Date: __________
(Applicant or Representative)

Relationship to Applicant: ______________________________