CORPORATE MEMBERSHIP APPLICATION FORM

Members are those persons, corporations, associations or partnerships who have contributed and paid to Osceola Community Hospital, Inc. d/b/a Osceola Regional Health Center (hereafter the "corporation" or the "hospital") a minimum of $100.00 or more to further the objectives of the corporation. Membership shall be lifelong and nontransferable. An exception is made in the situation where a membership certificate was issued in a single name and the membership certificate holder passes away. If this occurs, the membership certificate is automatically transferred to a living spouse.

Where two individuals have jointly contributed a minimum of $200 over their lifetimes, both are deemed to be individual members of the corporation. However, no person or entity may be a holder of more than one membership interest. Therefore, if the two individuals are individual members and one dies, the other individual does not become the owner of the deceased membership.

Each member whose name is endorsed on the membership certificate (or who obtained a membership certificate from a former spouse who has died) shall be qualified to originate and take part in the discussion of any subject that may properly come before the annual meeting of the corporation, to vote on such subjects, and to hold any office to which the member may be elected or appointed. However, no employee or employee's spouse of the corporation may be elected to the Board of Trustees of this corporation.

Membership Coverage

Please list the person(s) who will be covered under this membership.

Last Name: _____ First Name: _____

Organization Name (if applicable):_____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Additional Membership Coverage
(If more than one person covered)

Last Name: _____ First Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Payment Information

- MasterCard
- Visa
- American Express
- Other _____

Name on Card: _____

Card Number: _____

Expiration Date: _____ CVV: _____

Billing Address: _____

_____

_____

Signature: _____ Date: _____

Send to: Osceola Regional Health Center Phone: 712-754-2574

Attn: Administration

Fax: 712-754-2581

600 Ninth Avenue North
Sibley, IA 51249