FAIRCHILD MEDICAL CENTER

APPLICATION FOR AUXILIARY VOLUNTEER SERVICES

Date of Birth Day_____ Month_____

Application Date: _____

Application Received in Auxiliary Office: _____

Name: _____
Last First MI Spouse's Name if Married

Mailing Address: _____ Email Address: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact: _____
Name Phone

Personal References:

(1) _____ Phone: _____

(2) _____ Phone: _____

Special Training or Education: _____

Previous Work Experience: _____

Previous Volunteer Experience: _____

Community Affiliations (clubs, churches, other organizations): _____

Reason(s) for Wanting to Join our Volunteer Organization: _____

Do you have any physical condition(s) which may limit you from performing the position for which you have applied? Yes _____ No _____ If Yes, please explain what accommodation(s) you may need: _____

_____

Indicate the times you would be able to work below (mark all the apply): (Note: regular shift is 4 ½ hours per week, with a ½ hour lunch)

	Mornings 8:00 – 12:30	Afternoons 11:30 – 4:00
Monday	_____	_____
Tuesday	_____	_____
Wednesday	_____	_____
Thursday	_____	_____
Friday	_____	_____

Indicate areas in which you would be willing to work:

Information Desk	____
Gift Shop	____
Out-Patient Surgery	____
Emergency Room	____
Med/Surg	____

Would you be willing to substitute? Yes _____ No _____

_____
Signature of Applicant Date