## HANNIBAL REGIONAL HOSPITAL VOLUNTEER APPLICATION

Date//			Sex: •M • F	
Name:				
(Last)	(First)		(Middle)	
Home Address:				
	(City)	(State)	(Zip)	
E-Mail Address:	_ Home Phor	ne:	Cell Phone:	
Birthdate: Soc	Social Security Number:			
In case of emergency, who can we contact?				
	(Name)		(Relationship)	
Phone: (day) (evening)		(addres	ss)	
Highest Level of Education:		Maj	or	
School name (if currently attending)		S	school Phone:	
School Address:				
(Cit	ty)	(State)	(Zip)	
Are you currently employed? If s	o, where?			
Why do y9ou want to be a volunteer?				
Have you ever volunteered before? If so,	, where and wha	t was your work	assignment?	
The Auxiliary has general luncheon meetings on December. Do you want your name on a calling				
becomber, bo you want your name on a caning	nst to be called I	ioi iulicheon lese	rivations: 163 NO E-IVIAN	
The Auxiliary publishes a newsletter quarterly. [	Do you wish to re	eceive the newsle	etter by mail? •Yes •No	
Auxiliary dues are by membership classification said amount upon orientation:	. Please check y	our choice for me	embership and be prepared to pay	

Active members participate by hospital service and/or fundraising activities of the Auxiliary. Dues are \$10.00 per

year.

- Life members participate as active members described above, but pay a one-time total of \$200. (Payable in three payments) in lieu of annual dues.
- Sustaining members support the auxiliary with annual dues in lieu of active service and fundraising participation with annual dues of \$100.00. Sustaining members will not be called to donate to fundraising activities.

## PLEASE CHECK THE AREAS IN WHICH YOU WOULD LIKE TO VOLUNTEER:

		<ul> <li>Emergency Room</li> </ul>	<ul> <li>Puppet Making</li> </ul>	<ul> <li>Patient Accounts</li> </ul>
<ul> <li>Judy</li> </ul>		<ul> <li>Surgery Waiting Room</li> </ul>		
		<ul> <li>Cary Cancer Center</li> </ul>		
• Read	ding Program	<ul> <li>Children's Center</li> </ul>	<ul> <li>Fresh Flowers</li> </ul>	<ul> <li>Information Desk (walking required</li> </ul>
• Shu	ttle Service	<ul> <li>Greeter</li> </ul>	<ul> <li>Special Events</li> </ul>	<ul> <li>Caring Cup (Coffee Bar)</li> </ul>
• Har	nibal Free Clinic		<ul> <li>Knitting</li> </ul>	
Which c	lay/days of the wee	ek are you available?	·M ·T ·W ·TH ·F	·SA ·S
Which s	hift would you pre	fer? • 8:00 am – 12:00 p	om • 11:00 am – 3:00 pm	· 2:00 pm – 6:00 pm
Special	combination of day	/hours if needed		
*Hannil	oal Regional Hospi	tal Auxiliary shall not participate	e in any mandatory commun	ity service hours.
1) 2)	Undergo TB Testir Complete general Complete hospita	orientation program; specific de		
-		ted of any criminal offense other		
		terests:		
Tiobbles	s, skiiis & speciai iii	terests		<del></del>
REFERE	NCES			
1)	Name		Address	
	How does this pe	rson know you?		
2)	Name		Address	
ŕ	Phone: (Mobile)_		(Home)	
		rson know you?		
Believin	g that the organiza	tion has a real need of my servic	es as a volunteer, I will:	
•		conscientious in the fulfillment of		
•	Conduct myself w	ith dignity, courtesy and conside	ration;	
•				concerning a patient, doctor, or any member
		will not seek information in rega		
•		s, criticisms or suggestions to the	_	ces;
•		my work of the highest quality;		
•	Uphold the stand	ards of this organization.		
-	•	swers on this application are tru		isrepresentations or omissions of facts or
applicat		horize Hannibal Regional Hospita		the information submitted on this estigations and inquiries deemed necessary in
		Signature		 Date