



Membership Application

Name _____ Social Security Number _____
 Home Address _____ Home Phone _____
 City, State, Zip _____ Cell Phone _____
 Business Address _____ Occupation _____
 Person to contact in case of illness or injury while on duty: _____
 Phone _____ Relationship _____
 Previous Work Experience: _____
 A) As a Volunteer _____
 B) Special Training _____
 C) Hobbies, Skills Special Interest _____

Character References: 1) _____ Phone _____
 (not a relative) 2) _____ Phone _____

Type of service preferred: 1) Active ____ (50 hrs minimum service per year)
 2) Associate ____ (member only-doesn't volunteer)

Service Area Preferred:

- | | |
|---------------------------------------|--------------------------------------|
| _____ Information Desk | _____ Gift Shop |
| _____ Ambulatory Care Unit (ACU) | _____ Office Aide |
| _____ Nursing School Reception Desk | _____ Emergency Room |
| _____ Patient/Family Advisory Council | _____ Comprehensive Rehab Unit |
| _____ Magazine Distribution | _____ Hospice Office/Respite |
| _____ Surgery Waiting | _____ Pet Therapy Program |
| _____ Patient Floors/Ambassador | _____ Cancer Center Driver or Runner |

Days Preferred: ____ Monday ____ Tuesday ____ Wednesday ____ Thursday ____ Friday
 Hours Preferred: ____ Morning ____ Afternoon ____ Evening ____ Holidays

Birthdate _____ Signature _____ Date _____
 email address _____

FOR OFFICE USE ONLY

Date _____ Date _____
 PPD _____ Orientation _____ Uniform _____
 Hepatitis _____ background check _____ Conf notice _____
 Auth to photograph _____

Area: _____ Day: _____ Hours: _____

Entered In Computer _____