

Date: _____

Auxiliary Membership Application

I hereby make application for membership in the Hospital Auxiliary. I agree to uphold the purpose and policies of the Auxiliary and the institution that it serves. I understand that my membership is renewed upon payment of annual dues. Payment of \$5.00 for the year is attached.

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss	Name (Last, First, MI): _____
Address: _____	Home Phone: _____
City: _____	State: _____ Zip: _____
Are you under the age of 18? <input type="checkbox"/> Yes <input type="checkbox"/> No	Social Security #: _____ - _____ - _____
Have you ever been employed or volunteered at Calvert Memorial Hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes: Position held: _____ Dates: _____ to _____	
Type of Volunteer position desired: <input type="checkbox"/> Information Desk <input type="checkbox"/> Gift Shop <input type="checkbox"/> Other: _____	
Preferred Days: <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday	
Preferred Hours: <input type="checkbox"/> 8:00 am to 12:00 pm <input type="checkbox"/> 12:00 pm to 4:00 pm <input type="checkbox"/> 4:00 pm to 8:00 pm <input type="checkbox"/> Other _____	
Volunteer Experience:	
Skills, Special Interests, Hobbies:	
Community Activities:	
Licenses	
I would like to help with: <input type="checkbox"/> Bazaar <input type="checkbox"/> Bake Sale <input type="checkbox"/> Jewelry Sale <input type="checkbox"/> Committee Work <input type="checkbox"/> Knitting/Crocheting/Baby Caps/Booties <input type="checkbox"/> Other: _____	
Briefly explain why you want to volunteer:	
Have you ever been convicted of a criminal or civil offense other than a minor traffic violation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> When? _____	
If yes, explain: _____	
Can you perform functions of a volunteer without accommodations? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, explain: _____	
Give name and relationship of relative(s) presently employed by Calvert Memorial Hospital:	
Name: _____	Relationship: _____
Name: _____	Relationship: _____

Calvert Memorial Hospital
 Prince Frederick, MD

Auxiliary Membership Application

List three references who are not relatives or employers:

<i>Name</i>	<i>Address</i>	<i>Telephone</i>	<i>Occupation</i>
1.			
2.			
3.			

Person to contact in case of illness or emergency:

Name: _____ Telephone: _____

Please verify with your signature that all information you have given in this application is true and accurate.

PLEASE READ THE FOLLOWING STATEMENT CAREFULLY. IF THERE IS ANY PART YOU DO NOT UNDERSTAND, PLEASE ASK AUXILIARY STAFF TO EXPLAIN IT TO YOU.

I certify all statements made by me on this application are true and complete to the best of my knowledge and without consequential omissions of any kind. I also certify that I have not knowingly withheld any information that would affect this application unfavorably. I understand and agree that any false statement of omissions as discussed above with respect to the information required on this application is grounds for refusal to use my services as a volunteer or for withdrawal of any offer of volunteer assignment made to me or for the termination of my volunteer assignment at Calvert Memorial Hospital.

I authorize Calvert Memorial Hospital to investigate all matters covered by this application as well as all statements made by me on this application.

I also agree, if assigned, that I am to volunteer faithfully and diligently, to be careful and avoid accident, to come to my assignment promptly.

I agree to abide by all present and subsequently issued applicable policies and rules of the Hospital.

I also agree to become familiar with and abide by the Mission, Vision and Values set forth by the Hospital.

I understand that I am required to undergo required health and safety assessments and education on a periodic basis.

I understand transportation is my responsibility.

I understand that the keeping of confidentiality of information about patients, hospital records and employees is required. If I volunteer at Calvert Memorial Hospital, I understand that I will be required to maintain and protect the confidentiality of patient information medical records, patient and Hospital financial data and any patient, employee, physician, other volunteer member and Hospital information obtained through my volunteer assignment with Calvert Memorial Hospital. I further understand that violation of confidentiality would result in immediate termination of my volunteer assignment with Calvert Memorial Hospital.

I further understand that the CMH Auxiliary reserves the right to select the best qualified volunteer based upon all the information supplied on the application, interview process and reference checks. That decision is final and binding.

I hereby acknowledge that I have read and understand the above statements.

Signature: _____ Date: _____

FOR OFFICE USE ONLY

Volunteer Assignment:		Approved by Auxiliary:
Dues Paid:	Smock #:	Criminal Background Check:
Orientation:		Health Requirements:
Given Self Learning Packet (to be returned to the Department of Education and Training):		