APPLICATION FOR MEMBERSHIP/VOLUNTEER SERVICE

Please print

Date: _____ Name: _____
(Last) (First)

SSN: _____ Birthday: _____
(Month) (Day)

Address: _____ City/ZIP: _____

Telephone: _____ Cell Phone: _____ Email Address: _____

Referred By: _____

In case of an emergency, contact: _____

Relationship: _____ Telephone: _____

EMPLOYMENT EXPERIENCE

Company name: _____

Position: _____ May you be contacted at work? ❑ Yes ❑ No

Company Address: _____ City/State: _____

Telephone: _____ Name of Supervisor: _____

Other work experience/profession/positions held: _____

Education/Training: _____

Hobbies/Special Interests: _____

Language Proficiency *(other than English)*: _____

Why are you interested in volunteering at St. John's? _____

Specify dates of volunteer service: _____ ***Please mark times that you are available to volunteer:***

	M	T	W	TH	F	S	S
MORNING							
AFTERNOON							
EVENING							

Have you ever been a member of a hospital auxiliary before? ❑ Yes ❑ No

List any other volunteer/community service experience: _____

Have you ever been convicted of a crime? ❑ Yes ❑ No If yes, please explain: _____

Dignity Health
St. John's Hospitals
stjohnshealth.org

St. John's Regional Medical Center
1600 North Rose Avenue
Oxnard, CA 93030
direct 805.988.2500

St. John's Pleasant Valley Hospital
2309 Antonio Avenue
Camarillo, CA 93010
direct 805.389.5800

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Please circle any skills you possess that you would be willing to use in your work with the Auxiliary:

Accounting
Bookkeeping
Calligraphy
Cashiering
Community Education
Computer Work
Crafts
Customer Service
Decorating
Drawing
Editing
Event Planning
Filing
Flower Arranging
Fundraising
General Office Duties
Graphic Art/Design
Journalism
Marketing
Meeting Facilitation
Merchandising
Needlepoint
Photocopying
Photography
Plant Display
Poster Making
Public Relations
Reading
Receptionist
Recording Information
Retail
Sales
Secretarial
Sewing
Singing
Telephone *(answering and placing calls)*
Training
Typing
Video Recording
Writing Letters

Other: _____

_____

_____

Areas in which you would be interested in working:

1. _____
2. _____
3. _____

Do you have any physical/medical conditions we should be aware of? _____

Are there any work activities you must avoid? If so, please explain: _____

_____

Name of physician: _____ Telephone: _____

In order to provide the best possible service by St. John's Auxiliary to our hospital and its patients, a sixty-day probationary period has been established for all prospective members. This will give you an opportunity to observe the hospital as well as give the Auxiliary an opportunity to evaluate you. It is the responsibility of the chairperson/supervisor of each area to make recommendations for membership upon completion of the probationary/training period.

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OATH OF CONFIDENTIALITY

Information concerning the condition, care, or treatment of any patient must be held in strict confidence. Under NO circumstances should this information be disclosed to anyone.

I understand and agree that in the performance of my duties as a volunteer of St. John's Auxiliary, I must hold all medical information I obtain directly or indirectly confidential. Furthermore, I understand that intentional or involuntary violation of the hospital's policy on confidentiality may result in the termination of my volunteer services.

Initials _____

Please be sure to acquaint yourself with the Auxiliary Handbook during your training. Privilege to volunteer may be revoked for failure to comply with standards of conduct outlined for all personnel of St. John's Regional Medical Center and St. John's Pleasant Valley Hospital.

I authorize St. John's to administer a tuberculosis test, as required by hospital policy.

Active members pay annual dues of $10.00 and agree to commit to volunteer a minimum of 75 hours per year. We ask that you make every effort to fulfill your volunteer shifts. I agree to return the hospital picture ID badge if I decide to no longer be a member of the Auxiliary.

We look forward to your participation in the activities of St. John's Auxiliary.

_____ _____

Signature Date

For Office Use Only

INTERVIEW DATE/TIME:	UNIFORM PURCHASED:	AUXILIARY ORIENTATION:
NAME BADGE:	DUES PAID:	TB TEST TAKEN:
HOSPITAL ORIENTATION	AREA ASSIGNED:	AUXILIARY HANDBOOK:

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