#  **VCU Health Community Memorial Hospital Auxiliary**

1755 N. Mecklenburg Ave. • P. O. Box 90 • South Hill, VA 23970 Date:

### **Application for Membership**

## Membership in the Auxiliary shall be open to all individuals of at least eighteen years of age, who are interested in VCU Health Community Memorial Hospital and meet the approval of the VCU Health Community Memorial Hospital Auxiliary Interview Committee. This application must be completed in its entirety in order to be considered. Please leave no section unanswered, where information is requested.

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| --- |
| Personal Information |
| Name/Last/First/Middle Initial Birth Month/Date/Year |
| Mailing Address: Street or PO Box/City/State/Zip |
| Home Phone Number | Cell Phone Number | County | E-Mail Address |
| Have you worked in a Hospital before as a volunteer? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If so, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Can you operate a computer?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you out of town for lengthy periods of time? ­­­­­\_\_\_\_\_\_\_\_Why do you desire to become a member of VCU Health Community Memorial Hospital Auxiliary?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |
| Have you ever been convicted of, or have pending charges for, a felony ormisdemeanor (other than a minor traffic violation) either within the Commonwealth Yes Noof Virginia or anywhere else? If yes, please explain in detail. |
| Are you currently employed? \_\_\_\_\_\_\_\_\_\_ Have you ever been employed? \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Have you ever been employed? \_\_\_ |

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| --- |
| **Employer if/when applicable** |
| Name | Telephone No. |
| Address |
| **Most Recent Former Employer**  |
| Name  | Telephone No. |
| Address |
| **TWO REFERENCES ARE REQUIRED – NOT A RELATIVE** – (If a reference is an Auxiliary member, his/her signature is required below.) |
| Name | Address and Telephone No. | Years Acquainted |
| 1. |  |  |
| 2. |  |  |
| Auxiliary Member Reference’s Signature (if/when applicable) |
|  |
| Auxiliary Member Reference’s Signature (if/when applicable) |

Upon receipt of your application, you will be contacted to schedule an interview. If you are accepted as an Auxiliary member, you will be required to have criminal background checks, tuberculosis screening, and orientation. You will also be required to contribute at least forty-eight hours of volunteer service and attend an update annually. Six dollars annual dues are due on July 1. Dues are collected at the Annual Awards Luncheon in June. Flu shots are mandatory, unless medical or religious exemption is approved upon your request.

DEPARTMENTS OR AREAS WHERE VOLUNTEERS MAY BE ASSIGNED

Admissions/Registration

Cancer and Specialty Care Center

Emergency Department

Gift Shop

Hundley Center

Information Desk

Mammography

Marketing

Radiology

Rehab (Hospital)

Rehab (Rehab Center)

Surgical Waiting

**CHECK PROJECTS IN WHICH YOU MAY WISH TO GET INVOLVED**

Art Work \_\_\_\_\_\_\_\_\_\_

Baking Cookies and Other Sweets \_\_\_\_\_\_\_\_\_\_

Decorations (Christmas, Receptions, and other) \_\_\_\_\_\_\_\_\_\_

Fundraising \_\_\_\_\_\_\_\_\_\_

Tour Host or Hostess \_\_\_\_\_\_\_\_\_\_

Tree of Love - Elizabeth T. Moseley Scholarship Fund Program and Reception \_\_\_\_\_\_\_\_\_\_

I hereby certify that all information on this application, and any attachments hereto, are true and complete. I understand and agree that any falsification or omission of information herein, regardless of time of discovery, may cause forfeiture on my part to membership with VCU Health Community Memorial Hospital Auxiliary. I also understand that all information on this application is subject to verification, and that I will be asked to consent to criminal background checks during the course of the application process. I agree that VCU Health Community Memorial Hospital may contact any reference, employer, and/or educational institution listed on this application and I authorize VCU Health Community Memorial Hospital to rely upon and use, as it sees fit, any information received from such contacts.

I authorize VCU Health Community Memorial Hospital Auxiliary to contact any or all of my references for full information.

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 Applicant’s Signature

**To avoid possible delay in the application reaching the VCU Health CMH Auxiliary, please mail completed application to:**

 **Sylvia Lambert, Membership Chairperson, 600 Binford Street, South Hill, VA 23970-1512**

Revised: 6/6/23