MOUNTAINS COMMUNITY HOSPITAL AUXILIARY
Volunteer Application Form

Date__________________

____
Last Name (Please Print) First Name MI

____
Home Address PO Box City Zip code

____
Phone Number Cell Number

____
E-Mail address (Please Print)

____
Emergency Contact Name Address City Zip Code

____________________________ ________________________________
Phone Number Relationship

References:

Name:____ Phone Number:__________________________

Name____ Phone Number:__________________________

Would you be able to offer proof that you are at least 25 years of age? Yes____No____

In order to evaluate your application and determine whether we will be able to offer you a place on our team, we would like to get to know you better. As you answer the questions below, please feel free to attach additional pages if needed.

Are you willing and able to **commit 10 hours/month** of service to Mountains Community Hospital Yes___ No___

Are you willing and able to commit to a regularly scheduled **4-hour shift** each week. Yes___ No____

Please share with us why you would like to volunteer at Mountains Community Hospital____
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What expectations do you have regarding volunteering at Mountains Community Hospital
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Do you have previous volunteer experience? If yes, please list locations, positions held and dates for your previous experience. If no, please share life/work experiences that you believe will help you succeed as a hospital volunteer.
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Do you have any special skills, hobbies or interests you would be willing to share with us?____
____
____

Do you speak any other languages besides English? Yes____ No____ If so, what languages:_______________________

Do you have family members who work for Mountains Community Hospital? If so, please note their names and relationship to you.
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____

What days and times are you available to volunteer?
Please circle:

Monday	Tuesday	Wednesday	Thursday	Friday	
a.m. p.m.	a.m. p.m.	a.m. p.m.	a.m. p.m .	a.m. p.m.	Other______

Please circle your areas of interest:

Assist with activities in Skilled Nursing   Gift Shop   Boo Bears Sewing Group

Front Office   Rose Garden, trimming   Blue Jay Thrift Shop   Auxiliary Committee

Note: Positions assigned upon availability

The above information is accurate and complete to the best of my knowledge.

A mandatory background check will be conducted in order to complete the application process.

Signature____

Date____

Mail Completed form to: MCH Hospital Auxiliary
Attn: Membership
PO Box 813
Lake Arrowhead, CA 92352

Or drop application off at the Hospital Gift Shop:
29101 Hospital Road
Lake Arrowhead, CA 92352

We will contact you regarding the opportunity of volunteering at Mountains Community Hospital within 7-10 business days of receipt of your application.

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Office use only: Application Process: Please initial and date
Completed application received______________ Background check received and approved______________ Interview completed__________
Tour of facility completed_______________ Check received_______________ Hospital orientation completed_________________
TB test completed _____________ Update volunteer list completed_________ Information forwarded for Newsletter ______________