Interviewer ________________________
Service Assigned ___________________
Day ___________Time _______________

Auxiliary

MEMBERSHIP APPLICATION

Last Name	**First Name**	**MI**	**Social Security #**
Street Address	**City**	**State**	**Zip Code**
Home Phone	**Business/Cell**	**E-Mail Address**	
Emergency Contact Name		**Phone:**	

1. How did you become interested in Mission Hospital and the Auxiliary?
2. Are you now a student? If yes, where and what year?
3. Are you now employed? If yes, where?
4. Have you ever been employed by Mission Hospital? [ ] yes [ ] no
5. List participation in other community organizations.
6. Can you serve four (4) hours a week on a regular basis? [ ] yes [ ] no
7. Which days of week can you serve? [ ] week days [ ] weekends
8. What time of day can you serve? [ ] mornings [ ] afternoons [ ] evenings
9. Do you have physical condition or disability which may limit your ability to perform volunteer duties?
10. List any special interests or skills.
11. List any services that interest you the most.
12. References (please list two other than family):

Name	**Address**	**Phone**

13. Have you ever been convicted of a felony? [ ] yes [ ] no
If yes, state circumstances, place(s), dates(s):

Applicant Name:	**Page 2**
I understand that my volunteer status is pending satisfactory results of a TB test, background investigation, satisfactory proof of identity, as well as training and provisional periods. I hereby authorize Mission Hospital to make any investigation of my background deemed necessary.	**Initials**
I agree to conform to the rules and standards of Mission Hospital and the Auxiliary. I have read the core values of the hospital, listed below, and agree to adopt these values in my contact with patients, staff, physicians and visitors in this facility.	**Initials**
I certify that all answers or statements I have made on this application or other supplementary materials are true and correct without omissions. I acknowledge that any false statement or misrepresentation on this application or other supplement materials will be cause for immediate dismissal at any time during my association as a volunteer.	**Initials**

For Background Verification:

1. **Applicant's Date of Birth:** ________________

2. **If name change (through marriage or otherwise), print former name**______________

3. **Credit Report Required** _________________ **(for cashier positions)**

I understand that Mission Hospital is a **smoke free campus and my responsibility to abstain from smoking on the Mission Hospital campus.** I understand that non-compliance of this policy may result in disciplinary action, up to and including dismissal from the Auxiliary.

APPLICANT SIGNATURE **DATE**

The four **CORE VALUES** of Mission Hospital are the guiding principles for all we do. Each of us is committed to these values and work to make them present in our relationships with each other and with those we are privileged to serve. Our values continue a tradition of excellence and a dedication to help heal all those we touch.

Dignity
We respect each person as an inherently valuable member of the community and as a unique expression of life.

Excellence
We foster personal and professional development, accountability, innovations, teamwork, and commitment to quality.

Service
We bring together people who recognize that every interaction is a unique opportunity to serve one another, the community and society.

Justice
Advocate for systems and structures that are attuned to the needs of the vulnerable and disadvantaged and that promote a sense of community among all persons.