



AUXILIARY MEMBERSHIP APPLICATION FORM

Name: _____ Telephone #: _____

Home Address: _____

Business Address: _____

Date of Birth: _____ E-mail address: _____

Were you referred by a current or previous CMH Auxiliary member? ___ Yes ___ No
If yes, by whom: _____

Please list current or previous volunteer experience: _____

Current or previous occupation: _____

Education or Special Training: _____

List hobbies, skills, special interest: _____

List Community Affiliations (churches, clubs, other organizations): _____

Have you ever pleaded guilty or been convicted of any offense other than a minor traffic violation? _____ If yes, explain: _____

What service area in the hospital do you prefer to work in? _____

Days Preferred: Weekdays (Mon-Fri) _____ Weekends _____

Hours Preferred: Morning _____ Afternoon _____ Evening _____

Signature _____ Date _____

Please list two (2) references:

1. Name _____
Address _____

Phone # _____

2. Name _____
Address _____

Phone # _____

DO NOT WRITE BELOW LINE

AUXILIARY USE ONLY

Referring Auxiliary Members Recommends this applicant for Auxiliary membership:

Signature

Date

Membership Committee-Recommendations/Comments:

Recommendation for membership ____ Yes ____ No

Comments: _____

Membership Committee Representative Signature

Date

Executive Approval:

Signature

Date