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_____
_____
_____

What expectations do you have regarding volunteering at Mountains Community Hospital
_____
_____
_____

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.
_____
_____
_____
_____

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.

_____

_____

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 70
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 _____