Auxiliary Membership

Volunteer Form

Name: _____
(Last) (First) (Middle)

Address:_____
(Street) (City) (Zip)

Phone:_____
(Home) (Cell) (Work/Other)

Thank you for wanting to be a part of the Titusville Area Hospital Auxiliary. There are two membership options to choose from, Active and Supportive.

____ **Active Member** dues are $10 a year. As an active member you wish to volunteer your time in one of the listed volunteer positions and will have membership voting privileges. Active members must be 18 years of age or older. Please check the volunteer position(s) you are interested in:

____ Escort Desk: Volunteers greet and help direct people who come to the hospital. In addition, you deliver mail, cards and flowers to patients, assist with kiosk when necessary and assist with escorting patients to their vehicle when they leave the hospital. There are two shifts: 8:00 a.m. to 12 Noon and 12 Noon to 3:00 p.m. Monday through Friday.

____ Ways & Means: Assist the chairman with Auxiliary fundraisers such as Lights of Love and various fundraisers.

Please provide the number of days you are interested in volunteering per month: _____ and the shift you are interested in working: _____. Active members will be contacted to set up orientation and training for your volunteer position.

____ **Supportive Member** dues are $15 a year. As a supportive member you wish to support the activities of the Auxiliary and hospital but don't wish to serve in a volunteer position. As a supportive member, you do not have member voting privileges.

Emergency Contact:

1._____
(Name) (Relationship) (Phone)

2._____
(Name) (Relationship) (Phone)

Have you had any previous experience in a hospital setting? YES / NO (circle one)
If so, please explain_____

_____

Education/Training: Do you have any special training, hobbies or skills? _____

_____

Do you have any physical limitations? _____ If so, please explain: _____

_____

What other Volunteer/Service Organizations do you currently belong to: _____

_____

Briefly describe your reason for seeking a volunteer position at Titusville Area Hospital:_____

_____

_____

I understand that I am a volunteer, not a paid employee of the Titusville Area Hospital Auxiliary. I further understand that membership dues are required with the return of this completed form. Active membership is $10.00 per year. Supportive membership is $15.00 per year. Membership year is January through December.

During the time I am volunteering at Titusville Area Hospital, I understand that I must keep patient information strictly confidential. If I learn of certain information relating to patients, employees or other hospital-related business, I will treat this information as confidential.

Confidentiality of patient information must be maintained whether in written or verbal form. Patient-related information is never to be discussed in the lobby, hallways, elevators, snack shop or other areas where information may be overheard by other patients or visitors. All information concerning a patient, including the fact that he/she has ever been a patient at Titusville Area Hospital, *shall remain confidential*. It is your responsibility to refrain from and prevent the unauthorized disclosure of confidential information and to disclose information only to those individuals with a valid and authorized need.

Any volunteer may be asked to terminate service because of breach of patient confidentiality, unexplained absences or other unprofessional conduct.

I certify that all statements made by me on this application are true and complete. I authorize Titusville Area Hospital Auxiliary to inquire of references as to my qualifications and desirability as a volunteer. By signing below, I agree to abide by the policies and procedures of Titusville Area Hospital and the Titusville Area Hospital Auxiliary.

Signature:_____ Date:_____

Print Name:_____

Mail your completed form (and membership dues) to: Titusville Area Hospital Auxiliary
Membership Chairperson
406 West Oak Street
Titusville, PA 16354

Internal Use Only

Orientation Date:_____Specific Training Date(s) if required:_____

Completed by:_____ Starting Date:_____