Kona Community Hospital Auxiliary

MEMBERSHIP APPLICATION

③ *PERSONAL INFORMATION*

Name _____
First Middle Initial Last

Address _____
Street Address

_____
City State Zip Code

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____ Preferred Method of Contact _____

Are you 18 or older? ☐ Yes ☐ No

In case of emergency, please notify:

Name _____ Phone _____

③ *OCCUPATION/EDUCATION*

Employment Status: □ Employed □ Retired □ Self Employed □ Student □ Seeking Employment

Current or Last Employer _____

Position _____ Length of Time Worked _____

Education Level _____ Degree _____ Major _____

What language(s) other than English do you:

Speak _____ Read _____ Write _____

③ *REFERENCES* (Please provide all information requested for two people other than family members.)

Name _____

Address _____
Street address City State Zip Code

Phone _____ Length of time known _____

Name _____

Address _____
Street address City State Zip Code

Phone _____ Length of time known _____

③ *VOLUNTEER EXPERIENCE*

Organization _____ Length of Service _____

Roles/Duties _____

Organization _____ Length of Service _____

Roles/Duties _____

③ ***VOLUNTEER INTERESTS***

Please describe why you would like to volunteer with KCHA: _____

_____

_____

Please indicate your areas of interest. Check all that apply.

③ **Direct Patient Services**

□ Surgical Services □ Emergency Room □ Falling Star □ Book Cart □ Women's Health

③**Administrative Support**

□ Data Entry □ Marketing Assistant □ Contracts □ Copying/Filing □ Maintenance □ Cancer Center

③ **Fundraising**

□ Gift Shop □ Bake Sale □ Annual Fundraiser □ Other special fundraisers

③ **Community Outreach**

□ Media Announcements and Publicity □ Brochures and Publications □ Parades and Community Events

③ ***SCHEDULE PREFERENCE*** (Please indicate days and times that you are available to volunteer.)

_____

_____

③ ***BACKGROUND INFORMATION*** * Having been convicted of a criminal offense will not necessarily be held against you.

Have you ever been convicted of a criminal offense? □ No □ Yes □ Misdemeanor □ Felony

If yes, please explain: _____

③ ***MEMBERSHIP PREFERENCE***

□ **Active Member:** $10 per year; serve a minimum of 10 hours per year

□ **Sustaining Member:** $10 per year; no minimum service per year

□ **Patron Member:** $50 per year; no minimum service per year

□ **Lifetime Member:** $500 one time fee; no minimum service per year

==========

I certify that all responses on this document are true to the best of my knowledge. I agree that this information may be verified and references contacted by Kona Community Hospital. I understand that any misrepresentation of information constitutes cause for separation or termination from membership in the Kona Community Hospital Auxiliary and from volunteer service. I also consent and authorize Kona Community Hospital to conduct a background check, including past employment history/volunteer history, criminal record and other persons or sources as appropriate for the KCHA volunteer positions in which I have expressed an interest.

Signature: _____ Date _____

Kona Community Hospital Auxiliary is an equal opportunity organization.

Please return to: Human Resources - Kona Community Hospital, ATTN: KCHA
79-1019 Haukapila St., Kealakekua, HI, 96750

Questions: Call 322-4577 or email KCHAuxiliary@hotmail.com

(revised 9/17)