



Kona Community Hospital Auxiliary

MEMBERSHIP APPLICATION

● 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 _____

Applicants must be 18+ years of age to volunteer. Are you 18 or older? Yes No

In case of emergency, please notify:

Name _____ Phone _____

● 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 _____

● 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 _____

● VOLUNTEER EXPERIENCE

Organization _____ Length of Service _____

Roles/Duties _____

Organization _____ Length of Service _____

Roles/Duties _____

● **VOLUNTEER INTERESTS**

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

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

● **Direct Patient Services**

Surgical Services Emergency Room Falls Prevention Program Book Cart Women’s Health

● **Administrative Support**

Data Entry Marketing Assistant Contracts Copying/Filing Maintenance Cancer Center

● **Fundraising**

Gift Shop Bake Sale Annual Fundraiser Other special fundraisers

● **Community Outreach**

Media Announcements and Publicity Brochures and Publications Parades and Community Events

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

● **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: _____

● **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

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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., Kealahou, HI, 96750**

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