Kona Community Hospital
MEMBERSHIP APPLICATION

- ***PERSONAL INFORMATION***

Name: _____
First Middle Initial Last Name

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 an emergency, please notify:

Name: _____ Phone: _____

- ***OCCUPATION / EDUCATION***

Are you? ☐ Retired ☐ Student ☐ Other

What language(s) other than English do you use?

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 Dept. ☐ Book Cart ☐ Women's Health

  ☐ Imaging Services ☐ Medical Surgical Units ☐ Healing Touch (additional training required)

- **Department Support Services**

  ☐ Education ☐ Office Help ☐ Marketing Assistant ☐ Maintenance ☐ Cancer Center

- **Fundraising**

  ☐ Gift Shop (on hold) ☐ Annual Fundraiser ☐ Other Special Fundraisers

- **Community Outreach**

  ☐ Brochures and Publications ☐ Parades and Community Events

- ***SCHEDULE PREFERENCE*** (Please indicate days and times you are available to volunteer.) ☐ Select if you plan to volunteer more than 10 hours a week.

  _____

  _____

- ***HOW DID YOU HEAR ABOUT US?***

  ☐ KCHA Website ☐ Family/Friend ☐ Newspaper ☐ Radio ☐ Facebook

  ☐ Other Please Specify: _____

- ***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 at least 10 hours yearly.
  ☐ **Sustaining Member:** $10 per year; no minimum service per year.
  ☐ **Patron Member:** $50 per year; no minimum service per year.

I certify that all responses on this document are accurate 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 the information constitutes cause for separation or termination from membership in the Kona Community Hospital Auxiliary and 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 808-322-4577 or email KCHAuxiliary@hotmail.com