DELANO REGIONAL MEDICAL CENTER

Junior Auxiliary Application

Name _____
Last First Nickname (Spouse Name)

Address _____
Street City Zip Code Telephone

_____
Cell Phone (if applicable) E-mail Address (if applicable)

Birth Month: _____ Day: _____ ❒ Check here if under 18

In Case of Emergency Please Notify:

Name _____ **Relationship**_____

Phone _____ **or** _____

School Information (if applicable)

Name of School: _____ City: _____ Grade: _____

Current Employment (if applicable)

Company _____ Position _____

Address _____ Telephone _____

May we call if necessary? ❒ Yes ❒ No

Volunteer Information/Experience:

Please describe any volunteer experience or other experience which you feel would be helpful in serving DRMC's patients, visitors and employees: _____

_____

_____

Please list any special hobbies/interests/skills that could be included with your volunteering: _____

_____

_____

How did you become interested in our program? _____

_____

Times Available: ❒ Mon ❒ Tue ❒ Wed ❒ Thu ❒ Fri ❒ Sat ❒ Sun

❒ Mornings ❒ Afternoon ❒ Evenings Other _____

Areas of Interest:

❒ Gift Shop
❒ Bake Sales
❒ Special Projects
❒ Admitting/Information Desk
❒ Meal Ticket Sales
❒ Events
❒ Refreshment Cart
❒ Stock Vending Machine
❒ Filing/typing
❒ Mail Room
❒ Special Care Unit
❒ Computer

This is not an all-inclusive list and these positiions are subject to openings and availabillity.

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Please List Three References not related to you:

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

Have you ever been convicted of a felony? ☐ Yes ☐ No

Date of conviction: _____

NOTE: A conviction of a felony is not necessarily a bar to volunteer services. Each case is considered individually on the basis of nature of the crime.

Delano Regional Medical Center and it's Auxiliary Organization reserve the right to terminate volunteer service if a volunteer's performance standard is not in compliance with HFAP and State of California standards for volunteer services. A performance evaluation will be completed on all volunteers assigned to Delano Regional Medical Center. It is further understood that before I begin a volunteer assignment, I must first complete the required TB skin test and orientation training.

I have read and understand the above conditions of volunteer service.

Signature of applicant _____ Date: _____

PARENTAL PERMISSION REQUIRED

I hereby authorize my minor child to join the Delano Regional Medical Center Auxiliary as a Junior Volunteer.

_____ _____

Signature of Parent or Legal Guardian Date

Return application to: Becky J Gutierrez, 1401 Garces Highway, Delano, CA 93215

Call with Questions to 661-721-5208