VHC HEALTH AUXILIARY

1701 N. George Mason Drive, Arlington, VA 22205

703-558-6401

NAME ____ Birth Date _____________

ADDRESS ____

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Telephone # _____________________ Cell # _____________________

Email ___________________________________

List your current or your most recent employer? Please give dates & Job Title:

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How did you hear about the Auxiliary? ___________________________

Have you had any volunteer experience? Please list with dates:

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Do you have special skills? Circle all that apply.

Second language	Writing/Editing	Legal Training
Computer skills	Budget & Finance	Other: ______________________________

List two references:	**Relationship:**	**Phone number:**
____________________________	_______________	_________________
____________________________	_______________	_________________

Person to be notified in case of emergency:

Name ______________________________ Cell # ________________________

Home #_______________________Relationship _________________________

I understand that the first 90 days of my association with the auxiliary are deemed probationary. During this time the Auxiliary will assist me in finding a service suitable to my abilities and interests. I further understand that my membership in the VHC Auxiliary is conditioned on my satisfactory performance of the service to which I have been assigned and compliance with the rules and policies of the hospital and the Auxiliary. This includes adhering to the Patient Privacy rules of the hospital. Also, I agree to volunteer a minimum of 4 hours a week.

Upon my cessation of Auxiliary membership, I will return my VHC ID badge & parking pass.

Signed ____ **Date** _____________

Please mail the completed form to the above address.