

Hospital Auxiliary of the Los Alamos Medical Center, Inc.

Volunteer Application

Name: _____
Last First MI

Date: _____
E-mail: _____

Phone: _____

Birth Date: ____/____/____
Month Day Year

Home Address _____

Spouse Name _____

Emergency Contact _____ Phone # _____

Health Excellent () Fair () Good () Poor ()

Any limitations? _____

Previous work experience/Special Training

Hobbies and/or Specific skills _____

Community Affiliations _____
(Churches, clubs, other organizations)

Who referred you to the Auxiliary? _____

Do you know anyone who is now an active volunteer in this auxiliary? Yes () No ()

If yes, give name _____

Which day(s) and time of day is best suited for you to work regularly as a volunteer:

Signature

Which service is preferred?

In-Hospital Service

Information Desks _____

Lobby Shop _____

ATU _____

Arts and Crafts

Teddy Bears

Baby Blankets

Dues Paid _____

Date

Please return this completed form to the Lobby Shop

Must be vaccinated and boosted for COVID-19