Hospital Auxiliary of Aiken County, Inc.
Adult Volunteer Application
302 University Parkway
Aiken, SC 29801
(803) 641-5021

Applicants are considered for all positions without regard to race, color, religion, sex, national origin, age, marital or veteran status, or disability.

Name: _____ Date: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Telephone: _____ Cell phone: _____
Date of birth: Month: _____ Day: _____ Year: _____
E-mail address: _____
Spouse name: _____ (if applicable)
In case of emergency please notify: _____
Relationship to applicant: _____ Telephone: _____

References: (two required other than family members)
1. _____ Telephone: _____
2. _____ Telephone: _____

For security purposes, a background check will be done on all new volunteer applicants. Please signify you have read and understand the above statement by dating and signing this application.

Previous work experience: _____
_____
_____
Please list any special skills, training, or experience: _____
_____

Have you ever been convicted of a felony? _____
(Conviction will not necessarily disqualify you from becoming a member of the Auxiliary.)

Please share why you have an interest in volunteering at a hospital: _____
_____
_____

What area(s) of volunteering interest(s) you? _____
You may be assigned to the area of most urgent need.

What days and hours are you available to volunteer? _____

Statement of Understanding

I hereby give the Hospital Auxiliary of Aiken County, Inc., permission to contact the listed references and perform a background investigation and release Aiken Regional Medical Centers and the Auxiliary from any liability as a result of such contact. I understand that volunteer placement will be contingent upon receipt of satisfactory references, background check, a personal interview, completion of all initial and future health requirements as prescribed by hospital policy, and completion of orientation and training requirements.

Signature of Applicant: _____ Date: _____