Summerland Health Care Auxiliary
Membership Application

Name: _____

Address: _____

Postal Code: _____ Telephone No.: _____

Mailing Address (if different from above)

_____

_____

Email Address: _____

By providing your email address, you are permitting the Summerland Health Care Auxiliary to communicate with you by email. Your contact details will not be shared with any third party.

Emergency Contact: _____

Emergency Contact Telephone No.: _____

Have you previously belonged to an Auxiliary? Yes___ No___

If 'yes' please identify the location. _____

Did you hold any offices in that Auxiliary? Yes___ No___

If 'yes' please specify. _____

Please review the Summerland Health Care Auxiliary constitution and by-laws as provided.

Summerland Health Care Auxiliary
Volunteer Intake Form

Name: _____ Date: _____

Volunteer Areas Available: Thrift Shop ____ ECU Friendly Visiting____ SHC Eye Surgery Host____

Availability: If interested in the Thrift Shop, please indicate the times you would be available to work.

Monday a.m. ___ **Tuesday a.m.___** **Wednesday a.m.___**

Thursday a.m.___ **Friday a.m.____** **Saturday a.m.___**

Tuesday p.m.___ Wednesday p.m.___ Thursday p.m.___ Friday p.m.___ Saturday p.m.____

What are some jobs you think you might be interested in doing at the Thrift Shop?

_____

_____

_____

Do you have experience working as a cashier? (If yes, give details)

_____

Do you have any physical limitations that might affect the types of jobs you would be able to do?

_____

Relevant work experience_____

_____

Interests, Skills, Hobbies_____

_____