

VIRGINIA HOSPITAL CENTER AUXILIARY

1701 N. George Mason Drive, Arlington, VA 22205
703-558-6401

NAME _____

ADDRESS _____

Telephone # _____ Cell # _____

Email _____

Who is your current or your most recent employer? Please give dates & Supervisor:

How did you hear about the Auxiliary? _____

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

Do you have special skills? Circle all that apply.

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

List two references:

_____ Phone _____
_____ Phone _____

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.