BAPTIST MEDICAL CENTER BEACHES AUXILLARY

MEMBERSHIP APPLICATION

Return To: Membership Chairman
Hospital Auxiliary
1350 13th Avenue South
Jacksonville Beach, Fl 32250

FOR AUXILLARY USE ONLY:
Date Received: _______________
Health Report: _______________
Interview: ___________________
Oriented: ____________________
Dues Paid: ___________________
Confid. Stm: _________________
Member Card: ________________
Assigned Dept: ________________
Yearbook:____________________

Optional Info:
Single: _____
Married: _____
Divorced: ____
Widowed: ____

Name: ____

Home Address: Street ____

City: ____State: ___________ Zip: ________

Home Phone: _________________________________Business Phone: _________________

Email Address: ____

Birth Date: ___________________________________Spouse's Name: _________________

Occupation: ____

In case of Illness Notify: ___________________________________Phone: _______________

Number of Children: ______________Ages: _______________________________________

Are you a primary care provider for anyone else? ____________________________________

References – please list names and addresses:

1.____Phone: _______________________

2. ____ Phone: _______________________

Do you know anyone in BMC Beaches Auxiliary? __________________________________

If so, please list their names: ____

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Applicants must be at least 18 years of age. A personal interview is also required.

Have you belonged to an auxiliary before? ______________________________________

If the answer is yes, what positions have you held? _______________________________

____

What special hobbies and/or talents do you have: _________________________________

____

What time commitment are you able to make: ___________________________________

Reason for volunteering: ____

(A form will be sent to your health care provider for medical clearance.)

Your physician's name: ____

Address: ____

Type of membership: Active _________ Associate: ____________ Life: ___________

An ACTIVE member works as a volunteer at least 100 hours yearly. Annual dues of $10.00 are paid at the time of orientation, along with purchase of a uniform. Payment by cash or check only.

An ASSOCIATE member supports the auxiliary, but does not work. Annual dues are $15.00

A LIFE member pays $100 and is exempt from further dues. She/he may/may not work. This money may be paid through installments.

Previous business experience: ____

____

What type of assignment are you seeking: _______________________________________

HEALTH REFERENCE LETTER

Dear Doctor ______________________ Date: ______________

We have received an application for volunteer work in our hospital from
__________________________, DOB _______________ who has given us your
name as a health reference. Please complete the brief form below and return to the above address.
This information will be regarded as confidential.

This volunteer may be assigned to work directly with patients, and we would appreciate your
comments as to any limitations we should note in this regard. It is understood that the work
referred to is of a non-professional nature.

Thank you for your cooperation in helping us to extend our service to our community.

_______________________________ _______________________________
(Name) (Title)

I, _____________________________, give my permission on this date _______________
To BMC Beaches Auxiliary to obtain this medical release

Has the applicant any physical or medical disability about which we should know before making
an assignment? YES NO

Do you give this applicant medical clearance for hospital volunteer work? YES NO
You may use the reverse side of this letter for comments.

________________ __________________________
(Date) (Signature of Doctor)

Background Investigation

To be considered for volunteering with Baptist Medical Center Beaches or affiliates, applicants are subject to a background investigation with the Florida Department of Law Enforcement and other state, out-of-state, and local agencies.

Applicants are evaluated on the merits of their qualifications for positions available regardless of the individual's race, sex, color, national origin, age, disability, religion, marital status, or status as a veteran.

Have you ever been convicted of, or pled guilty, no contest or nolo contendere to a crime? This includes DUI or DWI, criminal conviction, debarment, sanction, or exclusion related to Medicare, Medicaid, or any other federal or state-funded health care program(s), or ineligibility for participation in a federally or state-funded health care program. ____ Yes ____ No
If yes, give details (date, place, offense(s), disposition, etc.): ____________________________
____

Have you ever been charged with a crime and either been placed on a court ordered probation, had adjudication withheld, entered a pre-trial intervention program, or have any criminal charges now pending?
_____ Yes _____ No If yes, give details __________________________
____

Please PRINT All Information and Sign at the Bottom

The following information is required to perform the background investigation:

- First and middle names should be as it appears on your birth certificate.
- In the *other* name field, include all last names that you have ever had.

Last Name ____

First Name ____

Middle Name ____

Other Name(s)____

Social Security # ______________________________________

Date of Birth/Year _____________________________________

FOR EMPLOYMENT OFFICE USE ONLY FDLE

Sex: Male____ Female ____ Race: White_____ Black____ Asian____
Hispanic____ Other____

Driver Lic. # ___________________________ State______________________

____ ______________________
Signature of Applicant **Date**