



**WORK PREFERENCE:** Choose the station where you would feel most comfortable working. Please mark 1<sup>st</sup> and 2<sup>nd</sup> choice with a 1 or a 2 on the lines.

Information/ Welcome Desk	Hours	_____	9:00 AM - 12:30 PM
		_____	12:30 PM - 4:00 PM
Gift Shop	Hours	_____	9:00 AM - 12:45 PM
		_____	12:45 PM - 4:30 PM
ICU Waiting Room	Hours	_____	8:00 AM - 11:30 AM
		_____	11:30 AM - 3:00 PM
		_____	3:00 PM - 5:00 PM
Surgery Waiting Room	Hours	_____	8:00 AM - 11:30 AM
		_____	11:30 AM - 3:00 PM

**SERVICE AREA:** Please check the area (s) where you would like to serve  
(Not required.)

Membership and Recruitment	_____
Scrapbooking	_____
Promotion and Publicity	_____
Newsletter	_____
Projects	_____

**ADDITIONAL INFORMATION:**

50 hours a year are required for active members.

Annual Dues: \$10.00 Active Members and Associate Members

Pay when you first begin, then once annually at Fall Meeting

Uniform: Uniforms are provided free of charge by the hospital. You will receive your uniform, badge, patch and parking tag once you have been approved.

Orientation: You are required by hospital policy to attend Orientation before being assigned to a regular work place. You will be contacted by the Vice President after you return this completed form. At orientation you will be asked to show your SS card (not a copy) and your drivers license. You will also take a written test and a drug test.

Mail application to Tami Davis, Northern Louisiana Medical Center, Ruston, LA 71270

Be sure to read your auxiliary handbook when it is given to you. It tells about dress code and rules of operation.

**CERTIFICATION AND AUTHORIZATION**

I certify that the information I have provided is true and complete to the best of my knowledge. I understand that misrepresentation, falsification, or omission of information may disqualify me from further consideration for volunteering, or may result in my termination as a volunteer.

If accepted as a volunteer, I understand that I must abide by all of the policies, rules and regulations of the Auxiliary and the Medical Center.

I authorize the Auxiliary to investigate all statements contained in this application and to make inquiries of my personal references and medical history, as well as other related matters as may be necessary for determining my eligibility as a volunteer. I hereby release physicians, employers, schools or individuals from all liability in responding to inquiries relating to my volunteer application.

Name: \_\_\_\_\_

Date: \_\_\_\_\_

(Adapted January 2011)