

Mills-Peninsula Health Services Auxiliary

Volunteer Application - Adult

Applying for service at: _____ Application date: _____

_____ Medical Center, 1501 Trousdale Drive, Burlingame, CA 94010, 650-696-5606

_____ Health Center, 100 S. San Mateo Drive, San Mateo, CA 94401, 650-696-4175

Applicant:

Name: First: _____ Last: _____ Birthday: ____ / ____ / ____
Month Day

Address: _____

City: _____ Zip Code: ____ -- ____

Home Phone: (____) ____ -- ____

E-Mail (optional) _____

Cell phone (optional): (____) ____ -- ____

Employment:

Present or most recent employer: _____

Can you be contacted at work? Yes No (circle one)

Telephone: (____) ____ -- ____

Education:

High School: _____ Graduated: Yes No

College/University: _____ Graduated: Yes No

Presently enrolled: Yes No If yes, where? _____

Background check and/or public record search:

Have you ever been convicted of a crime? * Yes No

If the above answer is yes, please indicate the following information for each conviction (*use reverse for additional cases*).

Date	Conviction	Court Name	City	County
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**Existence of convictions will not necessarily disqualify an applicant for employment; however, failure to fully disclose requested information may be considered falsification and will result in an offer being rescinded or may result in termination of employment upon discovery at any time during employment.*

Language Skills:

Language: _____ Circle: Speak Read Write

Skills:

Accounting	Fund raising	Retail/Sales	Typing
Art/Calligraphy	Public Speaking	Supervisory	Writing
Computer	Publicity	Technical	Other

Please circle those applicable to you.

Experience:

Volunteer work or other experience that may be helpful in placing you: _____

Briefly explain your reasons for volunteering: _____

How did you hear about us? _____

Days* and shifts preferred (please circle a.m. or p.m.)

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
a.m.	a.m.	a.m.	a.m.	a.m.	a.m.	a.m.
p.m.	p.m.	p.m.	p.m.	p.m.	p.m.	p.m.

* Limited weekend hours at Mills

References:

List two persons other than relatives who have knowledge of your character and/or education.

Name: _____ Address: _____ Telephone: _____

Name: _____ Address: _____ Telephone: _____

In case of an emergency, whom shall we notify?

Name: _____ Telephone: _____

Relationship: _____

Address: _____

Personal Physician: _____ Telephone: _____

Please read the following statements and sign below to acknowledge your agreement:

1. I certify that all information on the application is true and correct to the best of my knowledge. I understand that any error or omission may result in the Auxiliary rejecting my application for volunteer service.
2. If I am accepted as a member of the Auxiliary, I will work with my chairperson to get a substitute when I am unable to work as scheduled.

Applicant's signature: _____ Date: ___ ___ / ___ ___ / 20 ___ ___

For office use only	
Interview date: ___ ___ / ___ ___ / 20 ___ ___	Interviewer: _____
Placement: _____	Shift: a.m. p.m. Orientation date: ___ ___ / ___ ___ / 20 ___ ___
Dues: _____	Uniform: _____ HIPAA _____ Sign-In No. _____