BAPTIST Medical Center Beaches AUXILIARY

1350 13th Avenue South Jacksonville Beach FL 32250 (904) 627-1320

BAPTIST MEDICAL CENTER BEACHES AUXILIARY

MEMBERSHIP APPLICATION

Return to: Membership Chairman
BMCB Auxiliary
1350 13th Avenue South
Jacksonville Beach, FL 32250

Optional Info:

Single	□
Married	□
Divorced	□
Widowed	□

FOR AUXILIARY USE ONLY:

Date Received: _____	
Health Report:	□
Interview:	□
Oriented:	□
Dues Paid:	□
Confidential Statement:	□
Member Card:	□
Assigned Dept.:	□
Yearbook:	□

Last Name: _____ First Name: _____ Middle/Initial _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

E-mail 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: _____

Please list any auxiliary member(s) you know: _____

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

Have your 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 a 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? _____

_____

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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 <u>all</u> last names that you have ever had.

FOR HUMAN RESOURCES USE ONLY - FDLE

Last Name _____

First Name _____

Middle Name _____

Other Name(s)_____

Social Security # _____ Date of Birth/Year _____

Sex: Male_____ Female _____ Race: White____ Black_____ Asian____ Hispanic____ Other___

Driver Lic. # _____ State_____

Current Address: _____

Signature of Applicant: _____ Date: _____

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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 BMCB Auxiliary Membership at 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 BMCB 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: _____