DORMINY MEDICAL CENTER AUXILIARY

VOLUNTEER APPLICATION

SUBMIT COMPLETED APPLICATION TO:
Community Relations
Attention: Holley Lee
P.O. Box 1447
Fitzgerald, GA 31750
Email: hlee@dorminymedical.org

DATE: _____

NAME _____
LAST NAME FIRST NAME

ADDRESS _____
STREET CITY STATE ZIP

PHONE _____ TEXT: YES NO

IN CASE OF EMERGENCY, NOTIFY: _____
NAME PHONE

_____
RELATIONSHIP

PREVIOUS VOLUNTEER EXPERIENCE _____

_____

_____

_____

WHY DO YOU WANT TO VOLUNTEER WITH THIS ORGANIZATION? _____

_____

_____

REFERENCE: (REQUIRED) LIST ONE NON-FAMILY MEMBER

_____ PHONE _____

DAYS AVAILABLE FOR VOLUNTEERING (CIRCLE ALL THAT APPLIES): 10AM-2PM EACH WEEKDAY

MON. TUES. WED. THUR. FRI.

FREQUENCY OF VOLUNTEER AVAILABILITY: (weekly, semi-weekly, monthly, etc) _____

RECOMMENDED BY AUXILIARY MEMBER _____