Shands Lakeshore Regional Medical Center
368 NE Franklin Street
Lake City, FL 32055
(386) 292 - 8000

APPLICATION FOR AUXILIARY MEMBERSHIP

Last Name:________________________ First Name: _____________________ Middle Name: _________

Address: ____________________________ City: _______________ State: ______ Zip: ___________

Email address: ____

Telephone: ( ) _________________ Cell Phone ( ) ____________________

Social Security #: ______________________________ Have you ever served in an auxiliary: ______

Date of Birth: ________/_________/__________

Emergency Contact Name: _____________________ Emergency Contact Number: ________________

Cell Phone Number ____________________Email:____

Please indicate areas you would like to work:

Patient Care Areas

______ Day Stay Waiting Room
______ Floors
______ Information Desk
______ Emergency Room
______ Chaplin

Non Patient Care Areas

★ ______ Gift Shop
______ Surgery Waiting Area
______ Materials Handling
______ Human Resources
★ ______ Golf CarDriver

★ Minimum of 3 days training required gift shop.
★ Current valid drivers license required for car driver.

Please indicate the Day(s) and Time(s) you would like to work:

	8:00 - 12:00	12:00 - 4:00
Monday	_______	_______
Tuesday	_______	_______
Wednesday	_______	_______
Thursday	_______	_______
Friday	_______	_______
Saturday	_______	_______

Please tell us something about yourself :

Work Experience: ____
____
____

Special Abilities: ____
____

Interests: ____
____

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Please list two individuals who can provide a personal or work reference:

Name: ____ Telephone #:_____________________

Name: ____ Telephone #:_____________________

Have you ever been convicted of a felony? ☐ Yes ☐ No

Are you presently participating in a Mandated Volunteer Program ☐ Yes ☐ No

I agree to uphold the purpose and policies of the auxiliary and the insitution it services.

Applicant Signature: ____ Date: _____________

Name: (Please Print): ____

Please attach a copy of your Florida Drivers License & Social Security Card to this application. Thank you.

FOR HOSPITAL PERSONNEL USE ONLY

FOR OFFICE USE ONLY - PLEASE DO NOT PROCEED BEYOND THIS LINE

	BACKGROUND CHECK		DRUG TESTING
Date Entered	________________	Date Entered	_______ _________
Cleared	Yes_______________	Cleared	Yes________________
	No________________		No_________________

Signatures:

Human Resources Director ______________________________________

Occupational Health Nurse ______________________________________

FOR AUXILIARY USE ONLY

Approved for membership by President of auxiliary : ______________________________________