

*Lower Umpqua Hospital Auxiliary Application*  
600 Ranch Road- Reedsport OR 97467

NAME \_\_\_\_\_ HOME TEL. \_\_\_\_\_

ADDRESS \_\_\_\_\_ BIRTH MONTH \_\_\_\_\_

(For TB test notification)

Email \_\_\_\_\_

Annual dues :\$5.00 \_\_\_\_\_

Please list or explain previous type of work/volunteer/special interests:

Please list any foreign language interpretation skills you might share:

Please check below the areas where you would be interested in volunteering::

GIFT SHOP \_\_\_ INFORMATION DESK \_\_\_ LOBBY PLANT CARE \_\_\_ OUTSIDE GARDENING \_\_\_

SEWING \_\_\_ TELEPHONING \_\_\_ MEDICAL RECORDS \_\_\_ BOOK CART \_\_\_

EXTENDED CARE: BINGO \_\_\_ CRAFT PROJECTS \_\_\_ KNITTING \_\_\_ CROCHETING \_\_\_

MUSIC \_\_\_ READING ALOUD \_\_\_

COMMITTEES: SCHOLARSHIP \_\_\_ FUND RAISING \_\_\_ PUBLICITY \_\_\_  
NEWSLETTER \_\_\_ LEGISLATION \_\_\_ SILENT AUCTION \_\_\_  
HOSPITAL EMPLOYEES SAFETY CTE \_\_\_  
HOSPITAL EMPLOYEES EVENTS CTE \_\_\_

Please check days and times you might be available for volunteer assignments:

DAY	MORNING	AFTERNOON
Monday _____	_____	_____
Tuesday _____	_____	_____
Wednesday _____	_____	_____
Thursday _____	_____	_____
Friday _____	_____	_____
Saturday _____	_____	_____
Sunday _____	_____	_____

**CONFIDENTIALITY POLICY**

*As a member of the Lower Umpqua Hospital Auxiliary, I am required to observe the highest type of individual discretion. It is my responsibility to refrain from repeating anything confidential I learn in my association with patients and staff. Even the most casual statement could be detrimental to the staff, patients and or family resulting in court action involving me as well as the hospital.*

*I understand the hospital's policy and agree with its guidelines.*

Name \_\_\_\_\_ Date \_\_\_\_\_