



Trinity Hospital Auxiliary Membership Application

Name: _____ Spouse's Name: _____

Address: _____ email: _____

Telephone #: Home: _____ Work: _____ Cell: _____

In case of accident or emergency notify: _____

Relationship: _____ Telephone #: _____

Doctor's Name: _____ Telephone #: _____

What hobbies or interest do you have?

Activities you would like to participate in (e.g. crafts, visiting patients, grooming, shopping for patients' personal needs, working in the gift shop, etc.)?

What days and hours would you be available to help at the Hospital?

How did you learn of this auxiliary: _____

Background (previous employment, volunteer organizations, etc.):

Trinity Hospital auxiliary sponsor: _____

Personal Reference: Name: _____
Telephone # _____

Signature of applicant _____ Date _____

Signature of sponsor _____ Date _____

Membership committee recommendation: _____

Decision of group: _____