CLAXTON-HEPBURN MEDICAL CENTER AUXILIARY
APPLICATION FOR MEMBERSHIP

Each **active** member of the Claxton-Hepburn Medical Center Auxiliary must be at least 18 years of age and have at least 25 hours of volunteer services per year, pay dues on time, and must be supportive of Claxton-Hepburn Medical Center and promote health related services in our community and surrounding area.

SHOP COMMITTEE: This committee is for anyone interested in shop related activities. (shop clerk, shop committee member)

PUBLICITY COMMITTEE: This committee is for anyone interested in helping with publicity for all events, ideas to promote our image and the medical center's image in our community, handle some news releases and advertising.

CRAFTS COMMITTEE: This committee is for anyone interested in making crafts for our craft sales. No experience is needed. The craft committee meets on Thursday mornings or you may do crafts from home. The craft department meets off site of the medical center.

TELEPHONE COMMITTEE: This committee is for anyone interested in being a telephone caller when we need one. This committee is activated for special events throughout the year to keep the membership up to date on what is going on or when bake goods are needed for fundraisers or when the group is meeting for wakes & funerals of someone from our membership.

FUNDRAISING COMMITTEE: This committee is for anyone interested in helping at our fundraisers throughout the year. Some examples are baking or making candy for fundraisers, Jewelry Sale, Book Fair, Uniform Sale, volunteering at the sales, Festival of the Trees, etc.

BYLAWS COMMITTEE: This committee is for anyone interested in reviewing the CHMC Auxiliary Bylaws at least once per calendar year and making recommendations to the Auxiliary of any necessary changes.

SCHOLARSHIP COMMITTEE: This committee is for anyone interested in reviewing CHMC Auxiliary Scholarship applications in the Spring. This committee meets as a group to determine who our lucky winners will be. The scholarships are given annually at the Spring Dinner in May.

HISTORIAN COMMITTEE: This committee is for anyone interested in helping to organize our public relations by keeping a scrapbook and keeping up to date with our archives/records.

How did you hear about the Claxton-Hepburn Medical Center Auxiliary?____________________
____

List any previous volunteer experience:____
____
____

List skills, interest, and talents or comments (crafts, sewing, work in the shop)______________________________
____
____

I wish to be a member of the following committee(s):

______Shop Committee	______Publicity Committee	______Telephone Committee
______Crafts Committee	______Fundraising Committee	______Bylaws Committee
______Scholarship Committee	______Nominating Committee	______Outreach Committe

Please return this application with your annual dues included. Please make checks payable to Claxton-Hepburn Medical Center Auxiliary and mail to Claxton-Hepburn Medical Center Auxiliary, Attn: Ramona Kennedy, 214 King Street, Ogdensburg NY 13669.

NAME:____ DATE:_____________________

ADDRESS:____ D.O.B. / / ____________

PHONE:__________________________ EMAIL ADDRESS:___________________________________

ACTIVE $15.00 ______

FRIENDS OF THE AUXILIARY (ASSOCIATE) $25.00 ______

(Active membership must complete 25 volunteer hours annually and complete all annual requirements)
(Associate members can still be active but are not required to turn in volunteer hours, however it is very much appreciated if you do)

Have you ever been convicted of a crime? Yes or No ___________________________
If yes, describe in full:____
____
____

I certify that all answers given by me are true, accurate and complete. I understand that the falsification, misrepresentation or omission of fact on this application (or any other accompanying or required documents) will be cause for denial of volunteer employment or immediate termination of volunteer employment regardless of when or how discovered.

I authorize the investigation of all statements and information contained in this application. I release from all liability anyone supplying such information and I also release the employer from all liability that might result from making an investigation.

I consent to any and all job-related examinations, including pre-employment health, drug screening, and criminal background checks as required by Claxton-Hepburn Medical Center.

I acknowledge that I have read and understand the above statements and hereby grant permission to confirm the information supplied on this application by me.

X____
Auxiliary Member Signature **Date**

SS#_______________________________________ **(required for background check)**

For office use only:

HIRE DATE:	DECLINED:	NOT HIRED:
TERMINATION DATE: REASON FOR LEAVING CHMC:		