Hutchinson Health
AUXILIARY

Volunteer Information

Name: _____
(Last Name) (First Name) (Middle Name)

Address: _____
(Street) (City) (State) (Zip)

Home Telephone: _____ Cell Phone: _____

E-Mail: _____
(this will not be shared and will be used to send the Informer Newsletter)

Do you have any health problems or disabilities, which should be considered, before placement?
Yes No
If yes, please describe: _____

Have you ever been convicted of a crime? (This information will not be used in any manner which is inconsistent with M.S. Chapter 364).
Yes No
If yes, please explain: _____

_____

3M employee or retiree? Yes No

How did you become interested in our volunteer program? _____

_____

Which area would you like to volunteer at? Please mark all that apply.

- ❑ Thrift Shop
- ❑ Baby Stockings
- ❑ Baby Caps/Knitted Knockers
- ❑ Mail Messenger
- ❑ Walker Bags/Neck Pillows/Breast Pillows
- ❑ Information Desk/Gift Shop

Please turn over and complete backside →

For office use only:
☐ Dues paid and membership card given
☐ Info given to appropriate chairperson(s)
☐ Info entered in computer
☐ Info emailed to Board/Membership Chair & Newsletter Editor
☐ If 3M, let 3M chairperson know

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Volunteer Information

Please notify in case of emergency:
EMERGENCY CONTACT INFORMATION:

Last _____ First _____ Relationship _____

Home Phone _____ Work Phone _____

Cell Phone _____

Name of Physician _____ Phone _____

The above information is accurate and correct to the best of my knowledge:

Date: _____ Signature: _____

Please return form to

Hutchinson Health
Human Relations Representative
1095 Highway 15 South
Hutchinson, MN 55350