St Anthony's Memorial Hospital

Auxiliary Application

Name: _____
(Last) (First) (MI)

Spouse's Name: _____
(Last) (First) (MI)

Home Address: _____

☐ Single
☐ Married
☐ Widowed
☐ Other

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Birthdate: _____

Please check days and times usually available:

☐ Sundays ☐ Mondays ☐ Tuesdays ☐ Wednesdays ☐ Thursdays ☐ Fridays ☐ Saturdays

☐ Mornings ☐ Afternoons ☐ Evenings

In case of emergency, please notify:

Name: _____ Phone: _____

Applicant's Signature:_____Date: _____

Please return completed application to:

St. Anthony's Memorial Hospital
Community Relations Department
503 North Maple
Effingham, IL 62401

Submit

For Office Use Only

Orientation/Tour Date: _____
Orientation given by: _____

Uniform size:_____Amt pd.$_____

SAMH Orientation: _____
Other Comments: _____
_____
_____
_____
_____

Copies of application to:
_____President
_____Membership Recording Coor.
_____Community Relations Dept.
_____Human Resources Dept.
_____
_____
_____
_____
_____
_____

1/2000