SINGING RIVER
HEALTH SYSTEM
HOSPITALS

Dear Volunteer Applicant,

Thank you for your interest in serving as a volunteer with Singing River Health System. We are proud to partner with an outstanding group of community volunteers who serve our patients and guests with great compassion and commitment through our hospital auxiliary organizations.

Your application will be submitted to the membership committee of the hospital auxiliary to which you applied, and one of their volunteers will be contacting you soon. As they consider your application and suitability as a hospital volunteer, please keep in mind a few key requirements for serving as a volunteer with us.

All health system volunteers must:

- Pass a criminal background check and drug screening;
- Be in good physical health, able to walk extensively and able to assist patients in wheelchairs (up to 300 lbs), etc.
- Be available at least four hours per month during regular business hours, Monday – Friday;
- Be willing to commit to at least one year of active service;
- Be able to work independently;
- Be able to provide your own transportation;
- Exhibit the highest standards for customer service and commitment to their community.

You can expect to hear from our membership committee within four to six weeks of your original application date. Should you have any further questions regarding the application process, feel free to contact my office.

Again, thanks for your interest in serving as a hospital volunteer.

Sincerely,

Georgia S. Storey
Director, Guest Relations and Volunteer Services

SINGING RIVER HEALTH SYSTEM AUXILIARY VOLUNTEER MEMBERSHIP APPLICATION

I am interested in volunteering at: ❒ Ocean Springs Hospital ❒ Singing River Hospital

Name: ______________________________

Home Address: ______________________________

City: ____________ State: ______ Zip: ____________

Home Phone: ____________ Cell: ____________

Birth Date: ____________ email: ____________

Employment Experience (*Current/Past*): (Are you currently seeking employment? Yes ☐ No ☐)

____

____

Education or Special Training:

____

Community Affiliations (*i.e., PTA, Church, Scouts, etc.*):

____

List any physical or medical limitations:

____

Are you under the care of a physician? If so, please specify physician:

____

Are you able to push a wheelchair? ❒ Yes ❒ No

Name and Relationship of person who should be contacted in case of an emergency:

______________________________ Phone #: ____________

Service Preferred: ______________________________

Day(s) Preferred: ______________________________

Please tell in a few words your reason for wanting to join the Auxiliary: ____________

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____

Date: ____________ ______________________________

Signature of Applicant

Personal References:

(1) ______________________________ Phone #: ____________

(2) ______________________________ Phone #: ____________

Date of Orientation: ____________

Return application to either Hospital front desk or mail it to:

SRHS Guest Relations
2809 Denny Ave.
Pascagoula, MS 39581

Background and drug screenings are required.

Revised: 01/16