2016 Membership Application/Renewal Form

Applicant Information:

Name ____________________________________________________________

Position Title ____________________________________________________

Work Phone ____________________________   Work Fax ____________________________

Home Phone ____________________________   E-Mail ________________________________

Position Start Date ____________________________

Number of Years Experience in Managing/Coordinating Volunteers _________

WADVS Regional District ____________________________

Current Member of Association for Healthcare Volunteer Resource Professionals (AHVRP):

Yes _____   No _____

CAVS Certified:   Yes _____   No _____

Position Reports To ____________________________

Title _______________________________________

Address ______________________________________

City, State, Zip Code ____________________________

Facility Information:

Health Care Facility Name ____________________________

Type of Facility (ex. long term care, hospital, etc.) ____________________________

Address ______________________________________

City, Zip Code ____________________________

CEO ______________________________________

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Address ________________________________________________________________

City, State, Zip Code ______________________________________________________

Facility Number of Beds __________________________________________________

**Program Information:**

Number of Active Adult Volunteers _________________________________________

Number of Active Teen/Student Volunteers ________________________________

Structure of Volunteer Program (Check all that apply):

- ___ Auxiliary
- ___ Council
- ___ Partners/Friends
- ___ Volunteers (Non-Auxiliary)
- ___ Organization is affiliated with Partners of WHA

**Gift Shop Manager Information:**

Name ________________________________________________________________

E-Mail ________________________________________________________________

Phone Number _________________________________________________________

**Payment Information:**

Annual dues cost - **$65 (covers January 1 – December 31)**

- **2016 Annual Renewal Due Date – February 29, 2016**

Make check payable to **WADVS** and send, with completed application, to the WADVS treasurer at the following address:

**Send to:** Peggy McEvoy  
Coordinator of Volunteer Services  
Waukesha Memorial Hospital  
725 American Avenue  
Waukesha, WI 53188  
(262) 928-4869