fraserhealth Better health. Best in health care.

| ARH Hospital Auxiliary Registration Form | | |
|---|---|---|
| Last Name: | First Name: | |
| Address: | | |
| City | BC | Postal Code: |
| Telephone: | Cell: | |
| Email: | Birthdate:<br>D M Y *(Optional)* | |
| Hobbies/Interests: | | |
| ***Signature of New Member*** | Date | |

**Registration Form will be forwarded to the Auxiliary President for information purposes**

| **OFFICE USE ONLY** | |
|---|---|
| **Volunteer Application & Screening Completed:**<br>**DATE:** | **Hospital Orientation Completed:**<br>**DATE:** |
| **Membership Fees Received: $10.00** **DATE:**<br>***Cheques made payable to ARH Auxiliary*** | |
| **Registration Form & Fees to Auxiliary President: DATE:**<br>**President will forward Registration Form and dues to Membership Convenor: DATE:** | |

| **For Auxiliary Membership Convenor** | |
|---|---|
| **Phoning Convenor Notified** | **DATE:** |

***Revised: August 2018***