

Delta Health System-The Medical Center Auxiliary Membership Application

Date_____

Name_____

Address_____

City_____State____Zip_____

Home Phone_____Cell Phone_____

Person to contact in case of emergency_____

Phone Number_____

References (2 Required)

Name_____

Address_____

City_____State____Zip_____

Phone Number(s)_____

Name_____

Address_____

City_____State____Zip_____

Phone Number(s)_____

Days and times available to volunteer_____

Who can we thank for recommending you?_____

Applicant's Signature_____

Please fax this form to (662) 725-2066 or mail to:

Volunteer Services/HR

The Medical Center

PO Box 5247

Greenville, MS 38704