



# Association of Florida Healthcare Auxiliaries/Volunteers INCORPORATED

## MEMBERSHIP APPLICATION

Name of Auxiliary/Volunteer Organization \_\_\_\_\_

Number of Members \_\_\_\_\_ Active \_\_\_\_\_ Associate \_\_\_\_\_ Honorary \_\_\_\_\_ Other \_\_\_\_\_

Name of Healthcare Facility \_\_\_\_\_

Address	City	Zip Code	County
P.O. Box	Zip Code	( ) Telephone	Number of Beds

Chief Executive Officer's Name \_\_\_\_\_ Exact Title (i.e. CEO, President, Administrator) \_\_\_\_\_

Type of Facility: Not for Profit (NP) \_\_\_\_\_ Investor Owned (IO) \_\_\_\_\_ Government (GOV) \_\_\_\_\_

Type of Volunteer Services Rendered: Service \_\_\_\_\_ Fund Raising \_\_\_\_\_

Do you have officers? \_\_\_\_\_ Election Month \_\_\_\_\_ Month Installed \_\_\_\_\_

Do you have a Director of Volunteer Services? \_\_\_\_\_ Name \_\_\_\_\_

Do you have a TAV (Teenage Volunteer) Program? \_\_\_\_\_ How many TAVs? \_\_\_\_\_

Name of Auxiliary President/Volunteer Leader \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

( ) Telephone \_\_\_\_\_ Email \_\_\_\_\_

Signature of Person Who Executed This Application \_\_\_\_\_ Date \_\_\_\_\_

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(THE SPACE BELOW IS FOR AFHAV USE ONLY)

Approved By: \_\_\_\_\_ Date: \_\_\_\_\_

Resource Guide for Leaders issued to: \_\_\_\_\_

By: \_\_\_\_\_ Date: \_\_\_\_\_