



2020 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 _____

Address _____

City, State, Zip Code _____

Facility Number of Beds _____

Program Information:

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 _____

How did you hear about WADVS? _____

Payment Information:

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

- **2020 Annual Renewal Due Date – February 29, 2020**

To pay by credit card, please contact Peggy McEvoy at 262.928.4869

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**

I agree WADVS may release my photo for publicity, publications, or social media. I can withdraw authorization in writing any time, by contacting WADVS. I understand WADVS cannot recover information it has already released. I agree WADVS does not have any legal responsibility or liability for disclosing my photo. I agree not to request or accept anything in exchange for use of my photo.