APPLICATION FOR MEMBERSHIP

Individuals eligible for membership in the organization shall be those persons employed and recognized by the administration of health care organizations as responsible for the volunteer services programs within those institutions. Individuals must also be eligible for membership in the Association for Healthcare Volunteer Resource Professionals (AHVRP).

(PLEASE TYPE OR PRINT) Date: ___________________

Name:_______________________________________Title:____________________________________

Healthcare Organization:____

Address: ____

City: _____________________ State: ______ Zip Code:_____________County:________________

Office phone #:__________________________________Fax #:________________________________

Email Address:____

ORGANIZATION INFORMATION

Are you part of a healthcare system? ______ If so, Name of System: _____________________

Number of: Beds: ______________ Paid Staff in Volunteer Department: ______________

Is your organization a member of the American Hospital Association? _____ Yes _____No

Types of services provided by your organization: _______________________________________

____

Are you employed by your healthcare organization?__________ by the Auxiliary?_________

Does the Auxiliary reimburse your salary to your healthcare organization?_____________

To whom do you report (title only):____

Do you oversee volunteers? i.e., interview, placement? ________Your FTE status:________

What responsibility do you assume for the volunteer program?

Adult volunteers _________ College Students _________ Teenagers _________ Community groups _______

Guild/Auxiliary __________ Other: (please specify)____

Do you have any responsibilities other than volunteer management? _____Yes _____No

If yes, please identify: ____

PROFESSIONAL DATA

Previous employment/titles: ____

____

Education: ____

Years in volunteer management: ______ Years in healthcare volunteer management: ______

Are you certified in volunteer management? _____ Yes _____ No

If yes, give name of certification and sponsoring group(s): ___________________________________

____

List organizational affiliations: ____

____

Are you a member of the following organizations? (If yes, check)
_____ Association for Healthcare Volunteer Resource Professionals (AHVRP)
_____ Southeastern Directors of Volunteer Services in Healthcare Organizations (SDVSHO)

Committees/Offices held: ____

____

Have you ever been a member of NCSDVS in the past? _____ Yes _____ No
If yes, when: ______________ Reason for lapsed membership: ___________________________________

Establishment of Membership: Membership in NCSDVS shall become effective upon approval by the Membership Committee and receipt of a properly completed application form and payment of dues. Questionable applications may be referred to the Executive Committee for approval at the discretion of the Membership Committee.

Transfer of Membership: Membership in NCSDVS shall be transferable to a successor if dues were paid by a healthcare organization.

When membership has been approved you will receive a letter of acceptance, request for a current photo to be placed in the directory and payment instructions.

I acknowledge by becoming a member of this professional organization, it is an opportunity for me to gain further knowledge in the field of healthcare volunteer management that will benefit me personally and my healthcare organization. I commit to being a full member by participating in district meetings and the annual education conference as my healthcare organization commitments allow and by ensuring my annual membership dues are paid on time.

Electronic signatures: My typed name below shall have the same force and effect as my written signature.

Applicant's Signature: ____

Please return to the NCSDVS Membership Chair:

Nkpf c"Dqy ngu
Director, Volunteer Services
UNC Hospital
101 Manning Drive, Chapel Hill, NC 27514
(919) 966-4793 (office) / (919) 966-1389 (fax)

Revised
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