Massachusetts Association of Directors

MADHVS

of Healthcare Volunteer Services

Please complete the following application form and return it to

Brigid Roffe, Western Massachusetts Hospital 91 East Mountain Road Westfield, MA 01085

along with your **$40.00** check made payable to MADHVS:

Name:_____

Title:_____

Healthcare Organization:_____

Address:_____

City/Town:_____ Zip Code:_____

Office Phone: ( )_____ EXT: _____

Fax Number: ( )_____

E-Mail:_____

Cell (optional)_____

Type of Healthcare Facility: _____

To Whom Do You Report? (Just their title) _____

How Many Volunteers Annually Contribute to Your Organization? _____

Please Circle Your Answer:

Do You Belong to NEADHVS? Yes No

Do You Belong to ASDVS? Yes No

How were you referred to MADHVS? _____

What subject (s) would you most like to learn about?

_____

Would you be interested in serving in a leadership capacity in the future (board, committees)?

_____

Signature: _____ Date:_____