



ADULT VOLUNTEER SERVICES APPLICATION

Date: _____

PERSONAL INFORMATION

First _____ Middle _____ Last _____

Date of Birth _____ Social Security # _____

Driver's License # _____ Photo Copy [] Yes [] No

Email _____

Address _____

City _____ State _____ Zip _____

Phone _____ Secondary Phone _____

Do you speak any foreign languages? [] No [] Yes- If yes, please list. _____

EMERGENCY INFORMATION

Emergency Contact Name _____

Relationship to you _____ Home Phone _____

Work Phone _____ Cell Phone _____

QUESTIONNAIRE

1. Why are you interested in volunteering? _____

2. Are you currently seeking volunteer experience to fulfill a community service obligation (i.e. church, school)? No [] Yes [] – If yes, please describe the service requirements _____

Service Organization & Contact _____

Phone Number _____

3. Is there anything that may adversely affect your ability to perform volunteer duties? No Yes – **If yes, please describe in detail** _____

4. Are there any accommodations needed in order for you to safely and competently perform volunteer duties? _____

5. Please check all areas that you are interested in working in the hospital:

- | | |
|--|--|
| <input type="checkbox"/> Mailing & Clerical Projects | <input type="checkbox"/> ICU Intensive Care Unit |
| <input type="checkbox"/> Accounting, Budget & Payroll | <input type="checkbox"/> Infection Control |
| <input type="checkbox"/> Admitting / Discharge | <input type="checkbox"/> Information Desk |
| <input type="checkbox"/> Cafeteria | <input type="checkbox"/> Lobby Greeter |
| <input type="checkbox"/> Cardio-Pulmonary | <input type="checkbox"/> Materials Management |
| <input type="checkbox"/> Clinical Laboratory | <input type="checkbox"/> Medical Records |
| <input type="checkbox"/> Dietary | <input type="checkbox"/> Patient Floors |
| <input type="checkbox"/> Emergency Department Waiting Rooms or Registration only | <input type="checkbox"/> Radiology |
| <input type="checkbox"/> Engineering | <input type="checkbox"/> Rehabilitation Services |
| <input type="checkbox"/> Greeters | <input type="checkbox"/> Safety |
| <input type="checkbox"/> Hospital Events | <input type="checkbox"/> Waiting Rooms/Visitor Areas |
| | <input type="checkbox"/> Other: _____ |

EDUCATION & WORK EXPERIENCE

Education: Check highest level

High School: 9 10 11 12 GED

Name & State

If under 18, please list your primary interest of study/career goals _____

College: 1 2 3 4 Graduate School 1 2 3 4

Degree/Major _____

Employment Experience:

Have you ever worked at a hospital? Yes [] No []

Last Place of Work – if any: _____

Business Name _____

Address _____ Phone _____

Position _____ Supervisor’s Name: _____

REFERENCES:

Please include references for any current or former job supervisors, teachers or clergy. Family members, relatives and friends may not provide recommendations.

Reference 1 Name: _____ Phone: _____

Relationship to you: _____ Business Name: _____

Address: _____ City: _____ State: ___ Zip: _____

Reference 2 Name: _____ Phone: _____

Relationship to you: _____ Business Name: _____

Address: _____ City: _____ State: ___ Zip: _____

OTHER:

1. Have you ever been convicted or entered a guilty/no contest to a felony?

Yes [] No []

2. Have you ever been convicted or entered a guilty/no contest to a misdemeanor?

Yes [] No []

If ‘Yes’ to either question, please describe the conviction(s) in detail, including dates.

3. How did you hear about this volunteer program? _____

4. Do you hold any special medical or clinical certifications or licenses, or had medical training of any type? No [] Yes [] – Please list: _____

5. When can you start volunteering? _____

6. Check when you wish to volunteer. Shifts are typically 4 hours.

- [] Monday _____ to _____
- [] Tuesday _____ to _____
- [] Wednesday _____ to _____
- [] Thursday _____ to _____
- [] Friday _____ to _____
- [] Saturday _____ to _____
- [] Sunday _____ to _____

Certification and Authorization

I certify that the information I have provided is true and complete to the best of my knowledge. I understand that misrepresentation, falsification, or omission of information may disqualify me from further consideration for volunteering, or may result in my termination as a volunteer. If accepted as a volunteer, I understand that I must abide by all of the policies, rules and regulations of the Hospital.

I authorize the Hospital to investigate all statements contained in this application and to make inquiries of my personal references and medical history, as well as other related matters as may be necessary for determining my eligibility as a volunteer. I hereby release physicians, employers, schools or individuals from all liability in responding to inquiries relating to my volunteer application.

Name: _____ Date: _____