

Adult - For Internal Use: Certifications: _____

Community Service?

ADULT VOLUNTEER SERVICES APPLICATION

PERSONAL INFORMATION

First	_ Middle	Last			
Date of Birth	Social Security #				
Driver's License #	Photo Copy	[] Yes [] No			
Email					
Address					
City					
Phone	Secondary Pho	ne			
Do you speak any foreign languages? [] No [] Yes- If yes, please list.					
EMERGENCY INFORMATION					
Emergency Contact					
Relationship to you	Но	me Phone			
Work Phone	Cell P	hone			

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					
	s, please describe in detail				
4. Are there any accommodations need	ded in order for you to safely and as requested?				
 5. Do you have any physical, visual or No [] Yes [] – If yes, please 	r hearing needs we need to consider? ase explain:				
6. Please check all areas that you are	interested in working in the hospital:				
 [] Gift Shop [] Reception-Lobby-Greeter [] Marketing [] Women's & Children Wing [] Communication-Mailings-Marketing [] Senior Circle [] Healthy Woman [] Hospital Events 	 Information Desk Pastoral Care Waiting Rooms/Visitor Areas Education Other: 				

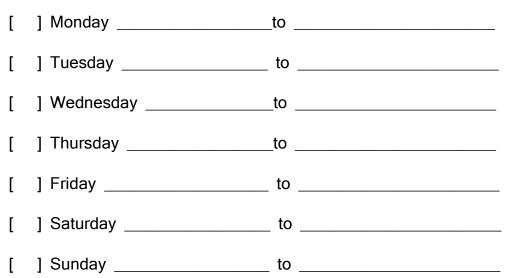
EDUCATION & WORK EXPERIENCE		
Education: Check highest level		
High School: 9 [] 10 []	11 []	12 [] GED []
Name & State		
College: 1 [] 2 [] 3 [] 4 [] Gr	aduate School	1[]2[]3[]4[]
Degree/Major		
Employment Experience:		
Have you ever worked at a hospital?	Yes []	No []
Last Place of Work – if any:		
Business Name		
Address		Phone
Position	Supervisor's Nam	ne:
REFERENCES:		
Reference 1 Name:		Phone:
Relationship to you:	_Business Name:	
Address: 0	City:	State: Zip:
Reference 2 Name:		Phone:
Relationship to you:	_Business Name:	
Address: 0	City:	State: Zip:
OTHER:		
1. Have you ever been convicted of a f 2. Have you ever been convicted of a r	-	Yes [] No [] Yes [] No []
If 'Yes' to either question, please describe t	he conviction(s)	in detail, including dates.
3. How did you hear about this volunt	eer program? _	
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4. Do you hold any special medical or clinical certifications or licenses, or had

medical training of any type?	No []	Yes [] – Please list:	cii

5. When can you start volunteering? _____

6. Check when you wish to volunteer. Each shift is 4 hours.



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: _____