

Confidential
VOLUNTEER SERVICES APPLICATION

Adult - For Internal Use: Certifications: _____ _____ Community Service? _____
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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 _____
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 work? No Yes – **If yes, please describe in detail** _____

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

5. Do you have any physical, visual or hearing needs we need to consider?
No Yes – **If yes, please explain:** _____

6. Are you physically able to transport patients in a wheelchair? Yes No

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

- | | |
|--|--|
| <input type="checkbox"/> Gift Shop | <input type="checkbox"/> Mail Room |
| <input type="checkbox"/> Accounting, Budget & Payroll | <input type="checkbox"/> Materials Management |
| <input type="checkbox"/> Admitting / Discharge | <input type="checkbox"/> Medical Library |
| <input type="checkbox"/> Cafeteria/Coffee Shop | <input type="checkbox"/> Medical Records |
| <input type="checkbox"/> Cardiac Cath Lab | <input type="checkbox"/> Oncology |
| <input type="checkbox"/> Cardio-Pulmonary | <input type="checkbox"/> Pastoral Care |
| <input type="checkbox"/> Case Management/Patient Advocate | <input type="checkbox"/> Patient Floors |
| <input type="checkbox"/> Clinical Laboratory | <input type="checkbox"/> Psychiatry |
| <input type="checkbox"/> Communications | <input type="checkbox"/> Physician Lounge |
| <input type="checkbox"/> Dietary | <input type="checkbox"/> Radiology |
| <input type="checkbox"/> Discharge Room | <input type="checkbox"/> Rehabilitation Services |
| <input type="checkbox"/> Education | <input type="checkbox"/> Recovery Room |
| <input type="checkbox"/> Emergency Department Waiting Rooms or Registration only | <input type="checkbox"/> Risk Management |
| <input type="checkbox"/> Engineering | <input type="checkbox"/> Safety |
| <input type="checkbox"/> Greeters | <input type="checkbox"/> Waiting Rooms/Visitor Areas |
| <input type="checkbox"/> Hospital Events | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> ICU Intensive Care Unit | _____ |
| <input type="checkbox"/> Infection Control | _____ |
| <input type="checkbox"/> Information Desk | |
| <input type="checkbox"/> Lobby Greeter | |

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 of a felony? Yes [] No []
- 2. Have you ever been convicted of 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. Each shift is 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: _____