

CONFIDENTIAL - ADULT VOLUNTEER SERVICES APPLICATION

For Internal Use: Certifications _____ Community Service _____ _____

Personal Information

First _____ Middle _____ Last _____

Date of Birth _____ Social Security # _____

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

Address _____

City _____ State _____ Zip _____

Phone # _____ Secondary Phone # _____

E-mail address _____

Do you speak any foreign languages? [] Yes [] No

If yes, please list _____

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Emergency Information

Emergency Contact _____

Relationship to you _____ Home Phone # _____

Work Phone # _____ Secondary Phone # _____

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Education and Work Experience

Education: Check highest level

School Name, City and State: _____

High School: 9 [] 10 [] 11 [] 12 [] GED []

School Name, City and State: _____

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

Degree/Major _____

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

Employment History

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

Last place of employment, if any, Name _____

Address _____ Phone # _____

Position _____ Supervisor's Name _____

Questionnaire

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 date(s).

3. Is there anything that may adversely affect your ability to perform volunteer work?

[] Yes [] No 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?

[] Yes [] No If yes, please describe in detail: _____

6. Are you physically able to transport patients? [] Yes [] No

7. Why are you interested in volunteering? _____

8. Are you currently seeking volunteer experience to fulfill a community service obligation (i.e. Church, school)? [] Yes [] No

If yes, please describe the service requirements _____

Service Organization and Contact _____

Phone # _____

9. How did you hear about our volunteer program?

10. Do you hold any special medical or clinical certifications or licenses or had medical training of any type Yes No

If yes, please describe _____

11. When can you start volunteering?

12. 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 _____

13. Please check all areas that you are interested in volunteering in this hospital.

- Information Desk
- Gift Shop
- Nursing Services (ICU, ER, Med/Surg, OB, Surgery)
- Ancillary Services (Lab, Pharmacy, Radiology, Rehab, Respiratory)
- Facility Services (Maintenance, Housekeeping, Dietary)
- Support Services (Accounting, Business Office, Human Resources, Patient Access, Marketing, Material Management)

14. Special Skills/Interests

Check the items, in which you have abilities or experience.

A. Technical _____

Typing _____

Filing _____

Computer Operations _____

Audio Visual _____

B. Creative _____

Sewing _____

Needlework _____

Musical Instruments _____

Photography _____

Art Work _____

Gardening _____

Calligraphy _____

Crafts _____

C. Other skills please list

References

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

1. Name _____ Phone #: _____

Relationship to you _____ Business Name _____

Address: _____ City _____ State _____ Zip _____

2. Name _____ Phone #: _____

Relationship to you _____ Business Name _____

Address: _____ City _____ State _____ Zip _____

3. Name _____ Phone #: _____

Relationship to you _____ Business Name _____

Address: _____ City _____ State _____ Zip _____

CERTIFICATION AND AUTHORIZATION

(Please read the following paragraph carefully before signing)

I certify that the information that I have provided is true and correct to the best of my knowledge and belief. I authorize Mineral Area Regional Medical Center (the "Company") to investigate my employment and personal history, including an inquiry concerning information on my criminal, credit and driving history, if appropriate. In connection with this investigation, I authorize all corporations, companies, credit agencies, educational institutions, persons, law enforcement agencies and former employees to release information they may have about me and release them from any liability or responsibility from doing so. This authorization, in original or copy form, shall be valid for this and any future investigation conducted by the Company. I am aware that if I am denied the opportunity to volunteer based on a report by a consumer-reporting agency, the Company will furnish the name and address of such agency upon my written request.

I understand that misrepresentation, falsification or omission of information may disqualify me from further consideration for volunteering or may result in my being dismissed 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 inquires relating to my volunteer application.

Name: _____ Date of Birth: _____

Address: _____

City, State, Zip _____

SS# _____ Driver's License # _____

Signature _____ Date: _____