

**MEDICAL CENTER ENTERPRISE**  
*Where Healthcare and Community Connect*

**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 \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ ( Home  Cell  ) Secondary Phone \_\_\_\_\_  
Do you speak any foreign languages? [ ] No [ ] Yes- If yes, please list. \_\_\_\_\_  
\_\_\_\_\_

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**EMERGENCY INFORMATION**

Emergency Contact \_\_\_\_\_  
Relationship to you \_\_\_\_\_ Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

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**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** \_\_\_\_\_

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

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

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**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"/> Cafeteria   | <input type="checkbox"/> Lobby Greeter               |
| <input type="checkbox"/> Case Management/Patient Advocate                        | <input type="checkbox"/> Pastoral Care               |
| <input type="checkbox"/> Education   | <input type="checkbox"/> Patient Floors              |
| <input type="checkbox"/> Emergency Department                                    | <input type="checkbox"/> Waiting Rooms/Visitor Areas |
| <input type="checkbox"/> Emergency Department Waiting Rooms or Registration only | <input type="checkbox"/> Other: _____                |
| <input type="checkbox"/> Greeters  | _____  |
| <input type="checkbox"/> Hospital Events   | _____  |
| <input type="checkbox"/> Information Desk  | _____  |

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**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: \_\_\_\_\_

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**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: \_\_\_\_\_

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**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.

\_\_\_\_\_

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**3. How did you hear about this volunteer 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: \_\_\_\_\_

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**5. When can you start volunteering?** \_\_\_\_\_

**6. Check when you wish to volunteer, or when you are available. Each shift is 4 hour shifts, but you can work more than one shift if desired.**

- [  ] 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: \_\_\_\_\_

