



**Community
Health Network**



AUTHORIZATION TO RELEASE INFORMATION

I HEREBY AUTHORIZE ANY OR ALL OF THE EMPLOYERS/ SCHOOLS/REFERENCES I'VE WORKED FOR/ ATTENDED TO FURNISH COMMUNITY HEALTH NETWORK WITH ANY INFORMATION THEY MAY HAVE CONCERNING ME OR MY RECORD. I HEREBY RELEASE EMPLOYER/ SCHOOL AND/ OR INDIVIDUAL FROM ALL LIABILITY IN FURNISHING THIS INFORMATION.

DATE

VOLUNTEER APPLICANT SIGNATURE

PRINTED NAME



Volunteer Services

Please check which Hospital location(s) you would prefer to volunteer.

- Community Hospital North**
7150 Clearvista Drive
Indianapolis, IN 46256
(317) 621-5289
- Community Hospital East**
1500 N. Ritter Ave.
Indianapolis, IN 46219
(317) 355-5503
- Community Hospital South**
1402 E. South County Line Road
Indianapolis, IN 46227
(317) 887-7145
- The Indiana Heart Hospital**
8075 North Shadeland Avenue
Indianapolis, IN 46256
(317) 621-8688

VOLUNTEER APPLICATION

DATE: _____

NAME: _____
Last First Mi

ADDRESS: _____
Street City State Zip

SOCIAL SECURITY NUMBER: _____

EMAIL: _____

TELEPHONE: Home: _____ **Work:** _____

EMERGENCY CONTACT PERSON: _____

Home Phone: _____ **Work Phone:** _____

EMPLOYMENT:

Name of Current Employer: _____

Have you ever been employed by any Community Health Network Hospital or Affiliate? YES NO

If Yes, position(s): _____ Date(s): _____

VOLUNTEER SERVICE:

Present Volunteer Position(s) _____

Previous Volunteer Experience: _____

REASON TO VOLUNTEER:

I want to volunteer because _____

How did you hear about Volunteering?

Current Volunteer (please include their first and last name) _____

Current Staff Member (please include their first and last name) _____

Church School Newspaper Recruitment Event Internet

Other _____

VOLUNTEER AVAILABILITY:

Are you willing to be an active volunteer for at least 6 months? _____

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Morning							
Afternoon							
Evening							

SKILLS & INTERESTS:

Please list any special skills, interests or abilities that you would like to share with hospital patients and staff:

(i.e. computer, foreign language, sign language, sewing) _____

STUDENT INFORMATION: (Please complete if you are in high school or college only)

Education (Circle Last Grade Completed):

HIGH SCHOOL: 9 10 11 12 COLLEGE: 1 2 3 4

Name of School: _____ Grade Average: _____

Counselor Name: _____ School Phone: _____

Minor (Under 18)

Parent Permission: I hereby give permission for my son/daughter to become a member of the Community Health Network Volunteer Program. I also give permission for my son/daughter to have two TB tests and a Rebeoloa/Rubella Titer drawn as required by the Board of Health.

Parent/Guardian Signature: _____ Date: _____

Have you ever been discharged from any position? YES NO

If yes, explain: _____

Have you ever been convicted of a felony? YES NO

Do you have criminal charges pending? YES NO

If yes, give date and nature of conviction or pending charges: _____

STATEMENT OF COMMITMENT:

If accepted as a volunteer, I will fulfill my commitment of service and maintain annual education and health testing. I agree to observe all Community Health Network policies and procedures for volunteers including hospitality and confidentiality. I acknowledge that the Community Hospital Network will make a limited criminal history investigation and will verify information given in my application.

Applicant Signature

PERSONAL REFERENCES:

Please provide two (2) personal references (not relatives):

NAME	COMPLETE ADDRESS/CITY/ST/ZIP	PHONE	YEARS KNOWN
1.) _____	_____	_____	_____
2.) _____	_____	_____	_____

PLEASE READ CAREFULLY:

I certify the statements on this application are true and correct to the best of my knowledge. I certify that I am not currently debarred, excluded, or otherwise ineligible for participation in federal health care programs. I understand falsification, misrepresentation or omission of information requested in this application will result in immediate dismissal, regardless of the date of discovery. I understand the Network will make a thorough investigation including a criminal history of my entire personal history and may verify all data given in my application. I authorize such investigation and the giving and receiving of any information required by the Network and I release from liability any person giving or receiving such information now or in the future. I understand falsification of data given or derogatory information discovered as a result of this investigation may prevent my being accepted as a volunteer, or, if accepted, may subject me to immediate dismissal. I understand that my volunteering depends upon satisfactory references and successful completion of a physical examination, and meeting all hospital requirements. I also acknowledge and understand this application is not a contract of employment, and that if I am accepted as a volunteer, I will be an at-will volunteer and I may voluntarily leave my volunteer position upon proper notice or my volunteer position may be terminated at any time for any reason. I acknowledge that no written or oral statements or promises have been made to or relied upon by me regarding the length of my volunteer position or the reasons for which my volunteer position can be terminated. If accepted, I agree to abide by and conform to all rules, policies and procedures of the Network.

Applicant Signature: _____ Date: _____

