VOLUNTEER APPLICATION

Picture

Community Hospital Anderson
1515 North Madison Avenue
Anderson, IN 46011
(765) 298-5100

Date of Application: _____

Name: _____ Spouse: _____
(Last) *(First)*

Address: _____
(Street) *(City)* *(State)* *(Zip)*

Date of Birth: _____ Telephone Home:_____ Work: _____

Education: High School:_____ College: _____
(years completed) *(years completed/degree)*

Limitations: _____

_____

IN EVENT OF EMERGENCY: _____ Relationship : _____
(*Name)*
Phone: _____/_____ Employment: _____
(*Home)* *(Work)*

If Employed: Name of Current Employer*:* _____

Address: _____ Position/Responsibilities:_____

VOLUNTEER SERVICE: Present Volunteer Job(s): _____
Previous Volunteer Job(s): _____

Hospital employees/Auxiliary members at Community Hospital acquainted with: _____
_____
_____

Referred by: _____
(Name) *(Address)* *(Phone No.)*

Days available to Volunteer (*Circle Preferences*):

MONDAY TUESDAY WEDNESDAY THRUSDAY FRIDAY

SATURDAY SUNDAY OPEN

WOULD BE AVAILABLE AS A SUBSTITUTE

Hours Available:

8:30 a.m. – 12:30 p.m.

12:30 p.m. – 4:30 p.m.

4:30 p.m. – 8:30 p.m.

(OVER)

AVAILABILITY: (Circle Preference)

ALL DAY *MORNING* *AFTERNOON* *EVENING*

SKILLS / PREFERENCES: (Please check all special skills and interests)

SKILLS	**WORK PREFERENCES**
☐ Good people skills	☐ Adults
☐ Calm Under Stress	☐ Children
☐ Typing	☐ Visitors / Families
☐ Answering Phones	☐ Patient Care
☐ Sewing	☐ Other Volunteers
☐ Crafts	☐ Individually
☐ Cashier	☐ Office
☐ Computers	☐ Public Reception Area
☐ Courier Service	

REASON TO VOLUNTEER:

I want to volunteer because: _____

_____

_____

PERSONAL REFERENCES:

Name Address Position

1. _____

2. _____

Please read carefully:

I will consider as confidential all information which I may hear directly or indirectly concerning a patient, a doctor, or any member of hospital personnel. I will not express curiosity in regard to a patient beyond the carrying out of my duties.

I have read the above and declare that the facts contained in this application are true and complete. I understand that if accepted, any false statements on this application will be cause for termination of my services. I hereby authorize Community Hospital and its Auxiliary to contact former employers, schools and other references concerning my past work experiences.

_____ _____

(Signature) (Date)

Dues of $5 are payable in January of each year for adult volunteers only.

FOR AUXILIARY USE ONLY

Received: _____ Contacted: _____ Interviewed: _____

Start Date: _____ Area/Time: _____

Community Hospital Anderson

VOLUNTEER SERVICES

CRIMINAL HISTORY CHECK

APPLICANTS LEGAL NAME: _____

ADDRESS: _____

_____

_____

DATE OF BIRTH: _____

SOCIAL SECURITY NUMBER: (required)_____

GENDER: M F

RACE: _____

I authorize Community Hospital Anderson to perform a criminal history check on my record.

_____ _____

Applicants Printed Name Applicants Signature

_____

Date