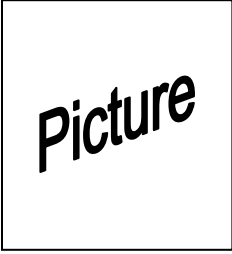


VOLUNTEER APPLICATION



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 THURSDAY 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.

AVAILABILITY: (Circle Preference)

ALL DAY

MORNING

AFTERNOON

EVENING

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

SKILLS

WORK PREFERENCES

- Good people skills
- Calm Under Stress
- Typing
- Answering Phones
- Sewing
- Crafts
- Cashier
- Computers
- Courier Service

- Adults
- Children
- Visitors / Families
- Patient Care
- Other Volunteers
- Individually
- Office
- Public Reception Area

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: _____	



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