

VOLUNTEER APPLICATION

PERSONAL INFORMATION

Name: _____ Date: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

E-mail address: _____

Home Phone: _____ Work/Cell Phone: _____

How did you hear about our Volunteer Program? : _____

AREAS OF VOLUNTEER INTEREST

- EVS Department
 My Life, My Story Program
 Patient and Family Advisory Committee
 Administrative tasks
 Special Projects
 Computer work

Availability

Please indicate the days and times you are available to volunteer.

| | <u>Sun.</u> | <u>Mon.</u> | <u>Tue.</u> | <u>Wed.</u> | <u>Thur.</u> | <u>Fri.</u> | <u>Sat.</u> |
|------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Morning | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Afternoon | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Evening | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Special skills and interests: (office skills, arts, crafts, music, language etc.) _____

EMPLOYMENT/WORK EXPERIENCE

Are you currently employed? Yes No

Employer: _____ Hours per week: _____

Past employment history: (list most recent)

Employer: 1. _____ 2. _____

Position held: _____

Date employed: _____

Reason for leaving: _____

| |
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| <p>PERSONAL REFERENCES</p> <p>Name: _____ Phone: _____</p> <p>Relationship: _____</p> <p>Name: _____ Phone: _____</p> <p>Relationship: _____</p> <p>Are you related to or do you know any employee or volunteer of Amery Hospital & Clinic? Yes No</p> <p>Name: _____</p> <p>Relationship: _____ Department: _____</p> |
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I certify that all statements on this application are true and complete to the best of my knowledge. I grant permission to Amery Hospital & Clinic to investigate references needed to complete the application process and I release the same from any liability resulting from such investigation. Volunteers who are at least 18 years old acknowledge that they will be subject to and must be cleared by a criminal background check. If selected as a volunteer, I understand that any omission, misrepresentation, or falsification of this record may be considered cause for termination. I further understand that as a condition of volunteering, Amery Hospital & Clinic requires that I be cleared through its own health screening process. If selected as a Volunteer, I will be required to attend a Volunteer Orientation as well as additional training where necessary. I will be required to sign a Confidentiality Policy Statement. I agree to observe all hospital regulations and policies. I understand that Volunteers are not covered by Worker's Compensation and that I am responsible for maintaining my own health insurance. I voluntarily offer my services with a clear understanding there will be no monetary compensation and that volunteering does not lead to employment.

Name: _____ Date: _____

Signature: _____ Date: _____

Email this completed application to doreen.j.snell@amerymedical.com. After receiving the application, the volunteer coordinator will contact you. If your skills and availability meet a need at Amery Hospital & Clinic, an interview will be scheduled.