VOLUNTEER SERVICES APPLICATION
CONFIDENTIAL

PERSONAL INFORMATION

First ________________________ Middle ________________ Last ____________________

Maiden Name:________________ Date of Birth_________ Social Security # ______________

Driver's License # _____________________ Photo Copy [ ] Yes [ ] No

Email ____

Address ____

City ___________________________________ State _____________________ Zip __________

Phone ________________________________ Secondary Phone __________________________

Do you speak any foreign languages? [ ] No [ ] Yes- If yes, please list. ______________

____

EMERGENCY INFORMATION

Emergency Contact ____

Relationship to you ______________________________ Home Phone __________________

Work Phone ____________________________________ Cell Phone ____________________

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 ____

1/09

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:

[ ] Gift Shop
[ ] Information Desk
[ ] Lobby Greeter & Escort
[ ] Marketing
[ ] Materials Management
[ ] Medical Records
[ ] Outpatient Surgery
[ ] Waiting Room - ICU
[ ] Waiting Room - Other
[ ] Other: ____

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 [ ]

Name of College________________________ Name of Graduate School____________________

Degree/Major ____

Employment Experience:

Have you ever worked at a hospital? Yes [ ] No [ ]

Last Place of Work – if any: ______________________________

Dates of Service: From______ To_____

Business Name ______________________________

Address ______________________________Phone ______________

Position ______________________Supervisor's Name: ______________________

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: ________

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. Each shift is 4 hours.

[ ] 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: _______________________________________

CERTIFICATION AND AUTHORIZATION FOR VOLUNTEERS

(Please read the following paragraph carefully before signing)

I certify that the information that I have provided is true and correct to the best of my knowledge and belief. I authorize Community Health Systems (the "Company") to investigate my employment and personal history, including an inquiry concerning information on my criminal, credit and driving history, if appropriate. In connection with this investigation, I authorize all corporations, companies, credit agencies, educational institutions, persons, law enforcement agencies and former employees to release information they may have about me and release them from any liability or responsibility from doing so. This authorization, in original or copy form, shall be valid for this and any future investigation conducted by the Company. I am aware that if I am denied employment based on a report by a consumer-reporting agency, the Company will furnish the name and address of such agency upon my written request.

____________________ Date

____________________ Print legal first, middle and last name

____________________ Social Security Number DOB

____________________ Driver's License # & State Issued

____________________ Street Address

____________________ City, State, Zip