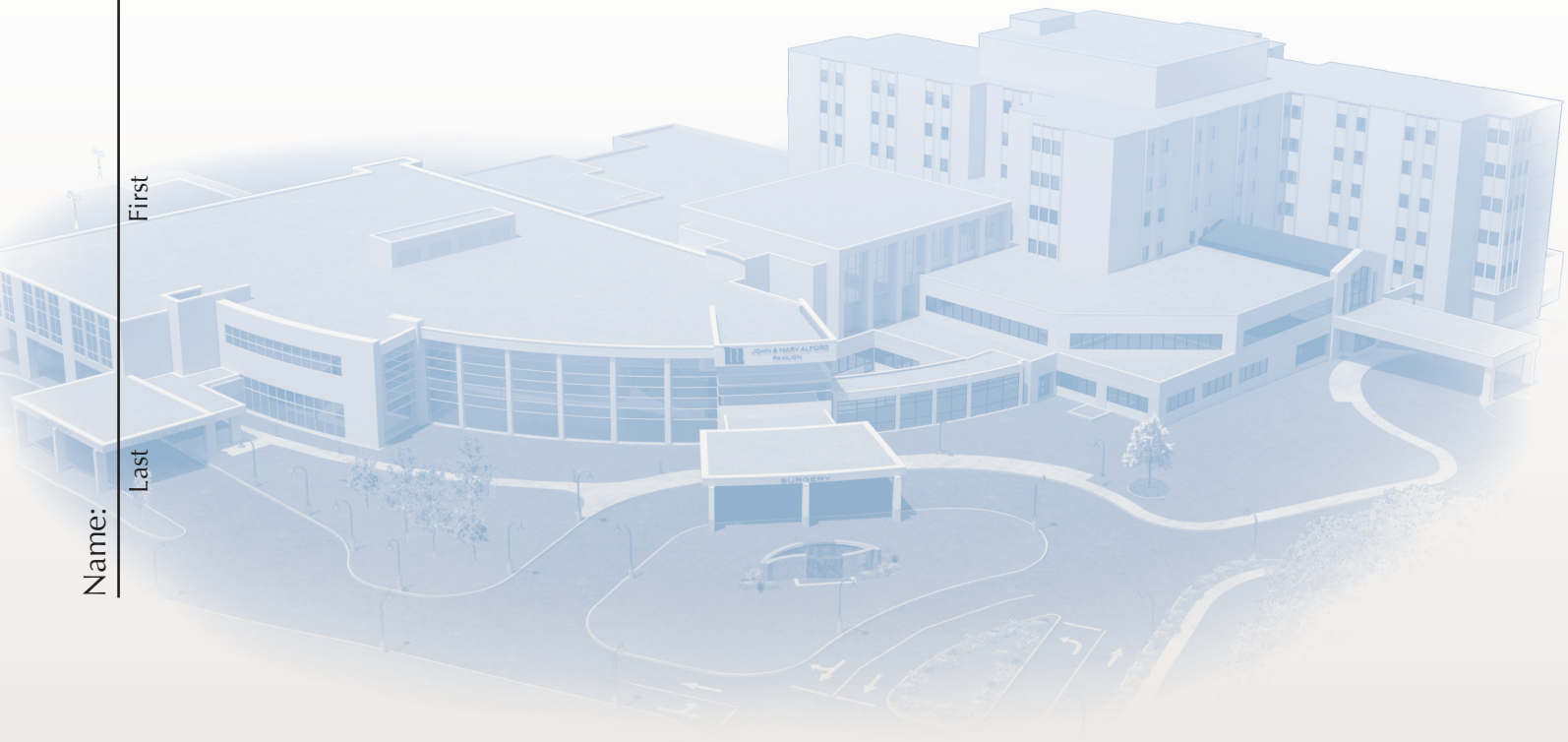
TWIGS: _____ Number

TWIGS Application

Name: _____ Last _____ First _____ Middle

TWIGS of
Licking Memorial Hospital

Togetherness, Willingness, Imagination, Giving, Sharing



TWIGS of
Licking Memorial Hospital
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TWIGS Application

Today's date: _____

GENERAL INFORMATION

Mr., Mrs., Ms., Miss: _____
Last name First name Middle initial

Address: _____
Street City State Zip code

Telephone: Home: (___)_____ Cell: (___)_____

Email: _____

Birthday (Month/day): _____

Completed education: [ ] High school [ ] College [ ] Post graduate degree

Degree(s): _____

Work status: [ ] Employed [ ] Unemployed [ ] Retired [ ] Homemaker

Last place of employment:_____

If presently employed, name of company: _____ Work phone: (___)_____

Position: _____ Work hours and days:_____

IN AN EMERGENCY, PLEASE NOTIFY:

Name:_____

Address: _____

Home phone: _____ Work phone: _____

Have you ever committed, been convicted of, pleaded guilty to, pleaded no contest to or entered a plea to a felony or misdemeanor?

Note: Conviction of a crime is not necessarily grounds for disqualification.

[ ] No [ ] Yes If yes, please explain _____

_____

SKILLS / INTERESTS

Do you currently work in retail or have you worked in retail in the past? [ ] Yes [ ] No

If yes, please explain: _____

_____

_____

How did you become interested in TWIGS? _____

_____

_____

Are there any work activities or conditions you must avoid? _____

_____

_____

Any additional information you care to add: _____

_____

_____

PERSONAL REFERENCES

Please do not use relatives as references. At least one reference for whom you have worked is preferred.

1. Name: _____ Occupation: _____

   Address: _____ City: _____ State: _____ Zip: _____

   Email: _____ Phone: _____

2. Name: _____ Occupation: _____

   Address: _____ City: _____ State: _____ Zip: _____

   Email: _____ Phone: _____

3. Name: _____ Occupation: _____

   Address: _____ City: _____ State: _____ Zip: _____

   Email: _____ Phone: _____

CONFIDENTIALITY/CONSENT

The information provided in this application is true in all respects without any willful omissions. I give my consent for a representative of the Volunteer Office or TWIGS to contact the references listed and to do a credit check and/or background check.

As a TWIGS volunteer, I would...

[ ] agree to complete the assigned training period until I have been deemed competent to perform the required duties.

[ ] agree to comply with all the rules and regulations of the Hospital and TWIGS.

[ ] understand that I may be dismissed from my duties for willful wrong doing or negligence and/or performing duties outside of my service description.

[ ] agree to follow established protocol should I not be able to work my assigned shift.

[ ] understand that TWIGS is not obligated to utilize my services as a volunteer, nor am I obligated to accept the volunteer assignment offered.

[ ] agree that I am performing duties as a volunteer and am not entitled to compensation.

CONFIDENTIALITY: It is the belief of this Hospital that all medical, financial and personal information pertaining to a patient is confidential and is protected from unauthorized viewing, discussion and disclosure. Therefore, TWIGS volunteers may review, use or disclose patient information ONLY as it relates to the performance of their duties. Any unauthorized viewing, discussion or disclosure will provide grounds for immediate dismissal.

I acknowledge and have read the statements above and agree to abide by the expectations of the TWIGS and the Department of Volunteer Services and LMHS.

Signed: _____ Date: _____

Opportunities for Volunteers are provided without regard to religion, creed, race, national origin, age, sex or disability.

Please return the completed application to:
Director of Development
Licking Memorial Hospital
1320 West Main Street
Newark, Ohio 43055
Development Department: (220) 564-4102

1970-DOC11
05/16/2021