

Volunteer/Volunteern Application

Date:

Middle

First

Name:

Last



Volunteer/Volunteer Application

Today's date: _____

GENERAL INFORMATION

Mr., Mrs., Ms., Miss: _____

_____ Last name First name Middle initial How do you want your first name to appear on your badge?

Address: _____

_____ Street City State Zip code

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

Birthday (Month/Day): _____ Email: _____

Are you at least 16 years of age? Yes No

Completed education: High school College Post-graduate degree

Degree(s): _____

Work status: Employed Unemployed Retired Homemaker

Current/Last place of employment: _____

Work phone: (_____) _____

Position: _____ Work hours and days: _____

Personal References

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

1. Name: _____

Address: _____
Please include city, state and zip code.

Occupation: _____ Email: _____

2. Name: _____

Address: _____
Please include city, state and zip code.

Occupation: _____ Email: _____

3. Name: _____

Address: _____
Please include city, state and zip code.

Occupation: _____ Email: _____

4. Name: _____

Address: _____
Please include city, state and zip code.

Occupation: _____ Email: _____

Note: Reference requests will be emailed unless otherwise indicated.

INTEREST / SKILLS

Please indicate with a check mark which you would be willing to share as a volunteer.

Clerical Skills

- Typing Answering phones Using copier Bookkeeping
 Record updating Numerical updating Using computer Alphabetizing
 Filing Other (specify)

Patient Care Services

- Patient escort Messenger service Visit patients
 Greet patients Other (specify)

Personal Skills

- Knitting Crocheting Sewing Crafting
 Creating art Playing a musical instrument
 Other (specify)

Additional skills/comments: _____

Special area(s) of interest in volunteering: _____

Would you be willing to volunteer, if called, to help with a special project such as stuffing and labeling envelopes, answering telephones or assisting with fundraising sales? Yes No

How did you become interested in our program? _____

What do you hope to gain from your volunteer experience? _____

Have you previously volunteered in a healthcare setting? Yes No If yes, describe your experience.

What about the healthcare setting is appealing to you? _____

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

VOLUNTEER AVAILABILITY

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
<input type="checkbox"/> a.m.	<input type="checkbox"/> a.m.	<input type="checkbox"/> a.m.	<input type="checkbox"/> a.m.	<input type="checkbox"/> a.m.	<input type="checkbox"/> a.m.	<input type="checkbox"/> a.m.
<input type="checkbox"/> p.m.	<input type="checkbox"/> p.m.	<input type="checkbox"/> p.m.	<input type="checkbox"/> p.m.	<input type="checkbox"/> p.m.	<input type="checkbox"/> p.m.	<input type="checkbox"/> p.m.

Comments: _____

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: _____

As a VOLUNTEER, I would...

- agree to attend the volunteer orientation and train until I am competent to perform the required duties.
- agree to comply with all the rules and regulations of the Hospital and the Volunteer Office.
- 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 call my assigned area or Volunteer Office as soon as possible when I have scheduling changes.
- understand that LMH 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 my duties as a volunteer and am not entitled to compensation.

Note: Reference requests will be emailed unless otherwise indicated.

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 to contact the references listed.

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, 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. Whenever it is questionable as to what information is confidential, it is your responsibility to discuss the matter with your supervisor before any breach of confidentiality occurs.

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

Signed: _____ Date: _____

Signature of Volunteer or Parent or Legal Guardian of Volunteer

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

Please return the completed application to:

**Volunteers Manager
Licking Memorial Hospital
1320 West Main Street
Newark, Ohio 43055**

Volunteer Department: (220) 564-4044

1970-0049
03/17/2020