Lutheran Health Network KCH

For Internal Use:
Certifications: _____

Community Service _____

ADULT
VOLUNTEER SERVICES APPLICATION

Thank you for your interest in the Kosciusko Community Hospital Volunteer Program. We are always looking for committed individuals that can devote several hours per week toward the service of our patients and their families. Because we take our commitment to our patients very seriously, we provide drug screening, TB testing, Security Background Checks, and educational opportunities to our perspective volunteers. Screenings, testing, background checks and in-house education is at the expense of the hospital.

If you feel that you would like to be a part of our volunteer program, please fill in the following application and our coordinator, Bonnie Height will be in contact with you. Thank you again for your interest in our program.

PERSONAL INFORMATION

First _____ Middle _____ Last _____
Date of Birth _____ Social Security Number _____
Driver's License Number _____ Photo Copy [ ] Yes [ ] No
Email Address _____
Home Address _____
y _____ State _____ Zip Code _____
Phone _____ Alternate Phone _____
Do you speak any foreign languages? [ ] No [ ] Yes- If yes, please list: _____
_____

EMERGENCY INFORMATION

Emergency Contact _____

Relationship to you _____ Contact's Home Phone _____

Contact's Work Phone _____ Contact's 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 _____

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3. Is there anything that may adversely affect your ability to perform volunteer work?

No [ ] Yes [ ] – If yes, please describe in detail _____

_____

_____

_____

4. Are there any accommodations needed in order for you to safely and competently perform volunteer work as requested? _____

_____

_____

5. Do you have any physical, visual or hearing needs we need to consider? No [ ] Yes [ ] – If yes, please explain: _____

_____

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
[ ] Emergency Department Waiting Rooms or Registration only
[ ] Host/Hostess: Out Patient Surgery
[ ] Out Patient Unit Support
[ ] Host/Hostess: Maternity
[ ] Host/Hostess: Beyer Building
[ ] Hospital Events (Healthy Woman)
[ ] Hospital Events (Senior Circle)
[ ] Information Desk
[ ] Cancer Center, Restocking, Filing
[ ] Mail Room
[ ] Materials Management
[ ] Other: _____

EDUCATION & WORK EXPERIENCE

Education: Check highest level

High School: 9 [ ] 10 [ ] 11 [ ] 12 [ ] GED [ ]

Name of School & State _____

If under 18, please list your primary interest of study/career goals _____

_____

_____

College: 1 [ ] 2 [ ] 3 [ ] 4 [ ] Graduate School 1 [ ] 2 [ ] 3 [ ] 4 [ ]

Degree/Major _____

Employment Experience:

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

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Last Place of Work – if any: _____

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 Code _____

Reference 2 Name: _____ Phone _____

Relationship to you: _____ Business Name: _____

Address: _____ City _____ State _____ Zip Code _____

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. _____

_____

_____

3. How did you hear about this volunteer program? _____

_____

_____

4. Do you hold any special medical or clinical certifications or licenses, or had medical training of any type? No [ ] Yes [ ] – Please list: _____

_____

5. When can you start volunteering? _____

6. Check when you wish to volunteer. Each shift is 4 hours.

[ ] Monday _____ to _____

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[ ] 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 _____