



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 _____
 _____ 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 _____

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:

- | | |
|--|--|
| <input type="checkbox"/> Gift Shop | <input type="checkbox"/> Hospital Events (Healthy Woman) |
| <input type="checkbox"/> Emergency Department Waiting Rooms or Registration only | <input type="checkbox"/> Hospital Events (Senior Circle) |
| <input type="checkbox"/> Host/Hostess: Out Patient Surgery | <input type="checkbox"/> Information Desk |
| <input type="checkbox"/> Out Patient Unit Support | <input type="checkbox"/> Cancer Center, Restocking, Filing |
| <input type="checkbox"/> Host/Hostess: Maternity | <input type="checkbox"/> Mail Room |
| <input type="checkbox"/> Host/Hostess: Beyer Building | <input type="checkbox"/> Materials Management |
| | <input type="checkbox"/> 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



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 _____

- 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 _____