Daviess Community Hospital

Application for Adult Auxiliary Volunteer Service

Volunteers are a vital part of our health care team at Daviess Community Hospital. Thank you for inquiring about our volunteer program. Questions on this application are to help us place you where both your interests and the needs of the hospital may best be met.

Please complete all information. Incomplete applications cannot be processed.

Date: _____

PLEASE PRINT

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ May we call you at work? Yes No

First name preference: _____

Do you currently volunteer for other organizations? Yes No

Highest level of education: _____

Please circle day(s) you are available: M T W TH F

Please circle time(s) you are available: 7:00 a.m. – 11:30 a.m. 11:30 a.m. – 3:30 p.m.

****It is suggested that volunteers work 4 shifts per month; however, volunteering for more shifts is appreciated and needed.**

Please list skills and special training. Include previous volunteer experience or employment.

_____

Have you ever pled guilty to or been convicted of a crime or crimes other than minor traffic violations?

Yes No If yes, explain: _____

Please list any health concerns: _____

_____

_____

Daviess Community Hospital

Emergency Contact:

Name: _____

Address: _____

Relationship: _____ Phone: _____

If you have been employed in the last 5 years, please complete this information below. Skip if you have not been employed within the last 5 years. Include both full and part-time work.

Dates of Employment: _____

Place of Employment: _____

Address: _____

Phone: _____

Duties performed: _____

Reason for leaving: _____

PLEASE LIST 3 REFERENCES (non-family; i.e. clergy, friend, supervisor, teacher, etc.)

First Reference

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Occupation: _____

Relationship: _____ How long have you known this person? _____

Second Reference

Name: _____

Address: _____

City/State/Zip: _____

Daviess Community Hospital

Phone:_____ Occupation:_____

Relationship:_____ How long have you known this person?_____

Third Reference

Name:_____

Address:_____

City/State/Zip:_____

Phone:_____ Occupation:_____

Relationship:_____ How long have you known this person?_____

I have completed the above information to the best of my ability and understand that any falsification of the information provided may prohibit me from volunteering. As a volunteer, I agree to hold confidential all information to which I may have access. This includes, but is not limited to, information on current, former or prospective patients and employees. Disclosure of such information to unauthorized persons is prohibited and may result in dismissal from the Auxiliary volunteer program and may have additional legal consequences.

_____

Volunteer Applicant Signature Date