VOLUNTEER APPLICATION
JUNIOR AND ADULT VOLUNTEERS
PLEASE PRINT

Personal Information

First Name: ____________________ Last Name: ____

Address: ____

City: __________________________________ State: _______ Zip Code: ______________________

Home Phone: ( ) ____________________________________ OK to call me here: ☐

Cell Phone: ( ) ____________________________________ OK to call me here: ☐

Work Phone: ( ) ____________________________________ OK to call me here: ☐

E-mail Address: ____________________________________ If you are selected to become a WMC Volunteer, we would like to keep you informed by e-mail of important information, volunteer opportunities and meeting reminders. Would you like to receive these e-mails? Yes ☐ No ☐

Are you a U.S. citizen? Yes ☐ No ☐

Age: Under 14 ☐ 14-17 ☐ 18 or Older ☐

Background Information

Have you previously been employed by Williamson Medical Center? Yes ☐ No ☐

If yes, state final position held, termination date and reason for leaving: ______________________

____

Have you been convicted of a crime? ________ If yes, describe in full, including dates: ______________

____

____

Demographic Information

The information collected below is optional. It is used only to help us better understand our volunteer force.

Gender: Male ☐ Female ☐ Birth Date: __________________________

Occupation (Present/Retired): ____

Check highest level of education completed: Elementary ☐ High School ☐

Trade School ☐ College ☐ Advanced Degree ☐

School, location, last year attended, area of study and diploma/degree received: ______________________

____

May 2008

Skills and Interests

Please describe any skills, hobbies and interests: ______________________________

____

Availability

Frequency you would like to volunteer:

Daily ☐ Twice Weekly ☐ Weekly ☐ Biweekly ☐ Monthly ☐

Please indicate the days and times you are usually available to volunteer:

	Sun	Mon	Tue	Wed	Thu	Fri	Sat
Morning:	☐	☐	☐	☐	☐	☐	☐
Afternoon:	☐	☐	☐	☐	☐	☐	☐
Evening:	☐	☐	☐	☐	☐	☐	☐

On what date will you be available to begin volunteer work? ______________________

Please specify any preference of unit or department: ______________________________

____

How did you learn about WMC's volunteer program? ______________________________

Why are you interested in volunteering at Williamson Medical Center? ______________________

____

____

References:

Individuals should not be related to you.

1. ______________________________ Phone: (   ) ______________
2. ______________________________ Phone: (   ) ______________
3. ______________________________ Phone: (   ) ______________

In case of an emergency, contact:

1. First Name: ____________________ Last Name: ______________________________________

Address: ____

City: __________________________________ State: _______ Zip Code: ______________________

Home Phone: (   ) ____________________________________ OK to call here: ☐

Cell Phone: (   ) ____________________________________ OK to call here: ☐

Work Phone: (   ) ____________________________________ OK to call here: ☐

Relationship: ____

2. First Name: ____________________ Last Name: ______________________________________

Address: ____

City: __________________________________ State: _______ Zip Code: ______________________

Home Phone: (   ) ____________________________________ OK to call here: ☐

Cell Phone: (   ) ____________________________________ OK to call here: ☐

Work Phone: (   ) ____________________________________ OK to call here: ☐

Relationship: ____

The undersigned volunteer agrees to abide by all Williamson Medical Center rules and regulations. Permission is granted to this Medical Center to investigate references and criminal background. I release from liability or responsibility all people, places of business and municipalities supplying such information.

I certify the above statements are made truthfully and realize falsification may result in dismissal. I understand my volunteering will be subject to a satisfactory investigation report, satisfactory check of my references and satisfactory post-medical screening, and my volunteering may be terminated by either party at will upon notice to the other.

Signature: ____ **Date:** ______________________

If under age 18, Parent/Guardian signature required below:

Signature: ____ **Date:** ______________________

Applicant also must read and sign Williamson Medical Center's Confidentiality Statement before serving as a Volunteer.