



CONFIDENTIAL
VOLUNTEER SERVICES APPLICATION
GADSDEN REGIONAL MEDICAL CENTER

For Internal Use:
Adult _____ Youth _____
Certifications: _____

Birth Date _____
Community Service _____

PERSONAL INFORMATION

First _____ Middle _____ Last _____
Date of Birth _____ Social Security # _____
Driver's License # _____ Photo Copy [] Yes [] No
Email _____
Address _____
City _____ State _____ Zip _____
Phone _____ Secondary Phone _____
Do you speak any foreign languages? [] No [] Yes- If yes, please list. _____

EMERGENCY INFORMATION

Emergency Contact _____
Relationship to you _____ Home Phone _____
Work Phone _____ 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? Yes [] No []

7. Please check all areas that you are interested in working in the hospital:

- | | |
|---|--|
| <input type="checkbox"/> Accounting, Budget & Payroll | <input type="checkbox"/> Medical Library |
| <input type="checkbox"/> Admitting / Discharge | <input type="checkbox"/> Medical Records |
| <input type="checkbox"/> Education | <input type="checkbox"/> Pastoral Care |
| <input type="checkbox"/> Engineering | <input type="checkbox"/> Waiting Rooms/Visitor Areas |
| <input type="checkbox"/> Greeters | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Hospital Events | _____ |
| <input type="checkbox"/> Information Desk | _____ |
| <input type="checkbox"/> Lobby Greeter | _____ |
| <input type="checkbox"/> Materials Management | _____ |

EDUCATION & WORK EXPERIENCE

Education: Check highest level

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

Name & 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: _____

Reference 2 Name: _____ Phone: _____

Relationship to you: _____ Business Name: _____

Address: _____ City: _____ State: ____ Zip: _____

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: _____

**CERTIFICATION AND AUTHORIZATION
FOR VOLUNTEERS**

(Please read the following paragraph carefully before signing)

I certify that the information that I have provided is true and correct to the best of my knowledge and belief. I authorize Community Health Systems (the "Company") to investigate my employment and personal history, including an inquiry concerning information on my criminal, credit and driving history, if appropriate. In connection with this investigation, I authorize all corporations, companies, credit agencies, educational institutions, persons, law enforcement agencies and former employees to release information they may have about me and release them from any liability or responsibility from doing so. This authorization, in original or copy form, shall be valid for this and any future investigation conducted by the Company. I am aware that if I am denied employment based on a report by a consumer-reporting agency, the Company will furnish the name and address of such agency upon my written request.

Date

Print legal first, middle and last name

Social Security Number

DOB

Driver's License # & State Issued

Street Address

City, State, Zip