Black River MEMORIAL HOSPITAL

VOLUNTEER APPLICATION

PLEASE PRINT

Today's Date: _____

Name: _____

Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____

Email: _____
For Volunteer Services use only.

Emergency Contact: _____ Phone: _____
Name/Relationship

Special training, skills, or interests: _____

_____

Do you speak a foreign language? ☐ No ☐ Yes; explain: _____

Community Affiliations: _____

_____

Referred by (name): _____ Phone: _____

Personal Reference (name): _____ Phone: _____

Address: _____
Street City State Zip

Area(s) of Volunteering Interest:

☐ Patient Services (Reception/Escort, Respite Care, "Lend an Ear" Volunteer, etc.)

☐ Community Outreach (Tele-Care Callers, Blood Drives, Diabetes Education Support Group, Appointment Reminder Calls, Cancer Support Group, etc.)

☐ Fundraising (Holiday Tea, Love Light Program, Vendor Sales, etc.)

☐ Other (Office Work, Telephoning, Knitting, Sewing, Cardmaking, etc.)

☐ Committee (Orientation, Scholarships, etc.)

Days of the Week Available: _____

Times of the Day Available: _____

Black River MEMORIAL HOSPITAL

VOLUNTEER APPLICATION

Reason for Volunteering: _____

_____

How did you hear about our Volunteer Program? _____

_____

I understand and agree that at no time will any information regarding patients be revealed to anyone other than those authorized to receive it. I understand that the giving of the information concerning a patient to those not authorized to receive information is unlawful and shall be sufficient cause for my immediate dismissal.

I agree to any necessary health screening required and understand my volunteer assignment is contingent upon successful completion of this screening, completing any necessary immunizations, attending orientation and, for hospice volunteers, completion of the hospice volunteer training program.

I understand that any false statements made as a part of this application may be considered sufficient cause for dismissal.

I authorize permission for all named references and educational institutions to release personal and professional information to the Volunteer Services office. I also consent to an annual police record search and a Department of Motor Vehicles check. I further release Black River Memorial Hospital, Black River Falls, WI, as well as those supplying said information from any and all liability from these investigations.

I UNDERSTAND THAT IF ACCEPTED AS A VOLUNTEER I WILL ABIDE BY THE GENERAL POLICY CONCERNING CONFIDENTIALITY. My assignment is on a probationary basis for a period of 70 days. I voluntarily offer my services with a clear understanding that there is no monetary compensation. I will observe all mandatory regulations.

_____ _____

Applicant Signature **Date**

FOR VOLUNTEER SERVICES TO COMPLETE

Interview Date: _____ Date Application Received: _____