



# COMMUNITY Hospital

## Application For Volunteer Service

Please print clearly

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First Middle Maiden

Address: \_\_\_\_\_  
Street City State Zip Code

Phone Number: \_\_\_\_\_

E-mail: \_\_\_\_\_

U.S. Citizen  Yes  No

Have you ever been convicted of a felony?  Yes  No

If yes, give details: \_\_\_\_\_

Service area of interest: (i.e. information desk, gift shoppe, clinical areas, etc.)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Availability:

Please circle:

Day: S M T W TH F SA

Time: Mornings Afternoons Evenings

Do you have any restrictions that might affect your volunteer placement with Community Healthcare Systems? \_\_\_\_\_

Current/Previous Work Experience: \_\_\_\_\_

Volunteer Experience: \_\_\_\_\_

Education/Special Training: \_\_\_\_\_

Skills: \_\_\_\_\_

Accomplishments/Hobbies: \_\_\_\_\_

Community Affiliations: \_\_\_\_\_

Who or what encouraged you to volunteer? \_\_\_\_\_

**References:**

1. \_\_\_\_\_

Name Address Phone #

2. \_\_\_\_\_

Name Address Phone #

List any friends or relatives employed or volunteering within the Community Healthcare System: \_\_\_\_\_

Emergency Contact : Name: \_\_\_\_\_

Address: \_\_\_\_\_

City State Zip Code

Phone: \_\_\_\_\_

**I authorize my references to provide information to Community Healthcare Systems that is relevant to my volunteerism.**

**Community Healthcare System is dedicated to providing quality health services, providing compassionate care of body, mind and spirit, and delivering superior service to our patients, families and visitors.**

**I also agree to respect the dignity and rights of each individual and maintain all information in the strictest of confidence. I understand that violations of any policy of the Community Healthcare System may result in the immediate dismissal from the Volunteer Program.**

**I understand that volunteerism is subject to conditions of the Drug Free Workplace Act of 1988.**

# Conditions of Volunteerism

Please read carefully

Please read the foregoing conditions of volunteerism. Your signature indicates that you agree to comply with the terms and conditions within:

1. By signing this application, I verify that the information contained in this application is correct to the best of my knowledge. False information may be grounds for rejection of my application or termination of service. Submission of this application does not automatically insure placement.
2. If placed, I will be required to have a health assessment and my continued volunteerism will be subject to my ability to satisfactorily perform the duties and responsibilities of my position.
3. Our selection is not based on race, creed, color, religion, national origin, age, sex, physical or mental disability.
4. In accordance with state Law IC 16-18-13 all candidates will be reference checked for a criminal history through the Indiana State Police Indianapolis Office. History of criminal conviction shall disqualify you from volunteerism within the Community Healthcare System.

I have read the foregoing Conditions of Volunteerism and I agree to comply with the terms and conditions therein:

In addition, I authorize investigation of all statements contained in my application. I understand that my volunteerism is contingent upon satisfactory completion of a drug screen (if applicable) Any statements made by me that are proven false may be considered cause for dismissal. I hereby authorize former employers and educational institutions, their officers, agents, or employees to furnish any information concerning my previous employment/volunteer record, job performance and character, and hereby release them from liability for reason thereof.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

Office use only:

Date of Birth \_\_\_\_\_

Social Security Number \_\_\_\_\_

# New Volunteer Checklist

(Official Use Only)

Service Description: \_\_\_\_\_

Date of Placement: \_\_\_\_\_

- Date of Birth \_\_\_\_\_
- Form of Identification \_\_\_\_\_
- 1<sup>st</sup> TB \_\_\_\_\_
- 2<sup>nd</sup> TB \_\_\_\_\_
- Reference Check \_\_\_\_\_
- Identification Badge \_\_\_\_\_
- Time Clock Number \_\_\_\_\_ (CH Only)
- Orientation \_\_\_\_\_
- Handbook \_\_\_\_\_
- Confidentiality Statement \_\_\_\_\_
- Code of Conduct / Corporate Compliance \_\_\_\_\_
- Hospital Values / Corporate Compliance \_\_\_\_\_
- Uniform \_\_\_\_\_
- Auxiliary Application \_\_\_\_\_

**Comments:**

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## Application For Student Volunteer Service

(Minimum age 15)

Please print clearly

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_  
Street City State Zip Code

Phone Number: \_\_\_\_\_

E-mail: \_\_\_\_\_

U.S. Citizen  Yes  No

Service area of interest:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Availability:

Please circle:

Day: S M T W TH F SA

Time: Mornings Afternoons Evenings

School: \_\_\_\_\_ Grade \_\_\_\_\_

Clubs and Activities: \_\_\_\_\_

Awards, Honors, Special Accomplishments: \_\_\_\_\_

\_\_\_\_\_

Volunteer Experience: \_\_\_\_\_

\_\_\_\_\_

Skills: \_\_\_\_\_

**References:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

**Emergency Contact:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Who or what encouraged you to volunteer? \_\_\_\_\_

\_\_\_\_\_

Are you volunteering because of school requirements?  Yes  No

If yes, how many hours? \_\_\_\_\_

Please read the foregoing conditions of volunteerism. Your signature indicates that you agree to comply with the terms and conditions within:

1. By signing this application, I verify that the information contained in this application is correct to the best of my knowledge. False information may be grounds for rejection of my application or termination of service. Submission of this application does not automatically insure placement.
2. If placed, I will be required to have a health assessment and my continued volunteerism will be subject to my ability to satisfactorily perform the duties and responsibilities of my position.
3. Our selection is not based on race, creed, color, religion, national origin, age, sex, physical or mental disability.

I have read the foregoing Conditions of Volunteerism and I agree to comply with the terms and conditions therein:

**Parental Consent:**

I hereby give permission for my daughter/son to volunteer and certify that all information in this application is correct. I give permission for my child to have a PPD test for tuberculosis and urine drug screen. I understand that my child cannot begin his/her service until the results of these tests have been confirmed.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**Student Commitment:**

Community Healthcare System is dedicated to providing quality health services, providing compassionate care of body, mind and spirit, and delivering superior service to our patients, families and visitors.

I also agree to respect the dignity and rights of each individual and maintain all information in the strictest of confidence. I understand that violations of any policy of the Community Healthcare System may result in the immediate dismissal from the Volunteer Program.

I understand that volunteerism is subject to conditions of the Drug Free Workplace Act of 1988.

\_\_\_\_\_  
Student Volunteer Signature

\_\_\_\_\_  
Date

Office use only: Date of Birth \_\_\_\_\_

Social Security Number \_\_\_\_\_

# New Volunteer Checklist

(Official Use Only)

Service Description: \_\_\_\_\_

Date of Placement: \_\_\_\_\_

- Date of Birth \_\_\_\_\_
- Form of Identification \_\_\_\_\_
- 1<sup>st</sup> TB \_\_\_\_\_
- 2<sup>nd</sup> TB \_\_\_\_\_
- Reference Check \_\_\_\_\_
- Identification Badge \_\_\_\_\_
- Time Clock Number \_\_\_\_\_ (CH Only)
- Orientation \_\_\_\_\_
- Handbook \_\_\_\_\_
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- Code of Conduct / Corporate Compliance \_\_\_\_\_
- Hospital Values / Corporate Compliance \_\_\_\_\_
- Uniform \_\_\_\_\_

Comments:

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