COLUMBUS REGIONAL HOSPITAL - VOLUNTEER SERVICES APPLICATION

2400 E 17th Street
Columbus IN 47201

Volunteer Services does not discriminate on the basis of age, sex, race or color, national origin, religion, or disability.

Date:________________________ **E-mail address:**________________________

Name:____
(Last) (First) (Middle) (Nickname)

Address: ____
(Street) (City) (State) (Zip)

Telephone #: Home:____________________ Work:____________________

In event of emergency: ____
(Name) (Phone) (Relationship)

Employment:

Name of current employer: ____

Position/Responsibilities: ____

Retired: ☐ No ☐ Yes If yes, please list last employer:____________________

Education: (circle last grade completed)

High School: 9 10 11 12 College: 1 2 3 4

College or Professional School Name:____

Degree/Diploma Received:____

Volunteer Experience: (List any present or previous volunteer activities or community affiliation, i.e. churches, clubs, organizations) ____

____

Reason to Volunteer: "I want to volunteer because . . . " ______________________________

____

Availability: (circle preference)

Time: All Day Morning Afternoon Evening ______________ # of hours/day

Day(s): Open Mon Tue Wed Thur Fri Sat Sun

Areas of Volunteer Service: (check all areas of interest)

☐ Surgery Waiting Room	☐ Information Desk	☐ Joint & Spine Ctr.	☐ Rehab (7 Tower)
☐ Gift Shop	☐ Floral Design	☐ Sponge Making	☐ Volunteer Chaplain
☐ ICU/CVU Waiting Room	☐ Clerical/Office	☐ Off-Site Locations	☐ Volunteer Office
☐ Chart Assembly	☐ Projects		

Special area of interest in volunteering not listed above: ______________________________

Columbus Regional Hospital Volunteer Services requires a criminal background check and reference check(s) on all volunteers. Direct patient care areas of volunteer service require a drug screening also.

I certify that all information on this application is correct and true, and I understand that any misrepresentation or willful omission of material facts will be sufficient reason for rejection of my application or, if volunteering, my immediate discharge.

______________________________ ______________________________

Signature **Date**

Volunteer Authorization to Investigate Background:

Columbus Regional Hospital Volunteer Services, in considering my application for volunteer services, may verify the information set forth on my volunteer application as well as additional information relating to my background, which I am providing. I authorize all, persons, schools, companies, law enforcement agencies and former employers to supply Columbus Regional Hospital Volunteer Services any information concerning my background and consent to the release of such information. I authorize Columbus Regional Hospital Volunteer Services to investigate all information and release Columbus Regional Hospital Volunteer Services from all liability and responsibility for furnishing any information concerning my background or confirming information, which I have provided. I have read, understand and agree to the statements above. I certify that the information on this form is true, correct and complete. I understand that if I am placed as a volunteer, I can be discharged for any misrepresentation or omission in the above statement. I also understand that if I am placed as a volunteer, my assignment is conditioned on receipt of a satisfactory background report and references.

Volunteer – please sign below and provide the following information:

____
Volunteer Name (Print)

____________________________________ **Date:** _______________________
Volunteer Signature

Volunteer Date of Birth: ______________________________

Volunteer Social Security Number: ____________________(optional)

References: (Other than a relative)

1. Name:______________________________ Phone:__________________
   Mailing address:________________________
   ____

2. Name:______________________________ Phone:__________________
   Mailing address:________________________
   ____