VOLUNTEER APPLICATION
Bradley Medical Center

DATE ____________________

PERSONAL INFORMATION (Please Print)

First ______________________ **Middle** ___________________ **Last** __________________

Address ______________________________________

City ____________________________ **State** ________________ **Zip** _________________

Date of Birth ____________________ **E-Mail** ________________________________

PHONE:

Home ______________________ **Work** ___________________ **Cell** __________________

EMERGENCY INFORMATION

Emergency Contact ____

Relationship to You _____________________ **Home Phone** _______________________

Work Phone ____________________________ **Cell Phone** _________________________

EMPLOYMENT EXPERIENCE

Have you ever worked in a hospital? ______________

Last Place of Employment ____

Address ____ **Phone** ___________________

Position _________________________ **Supervisor's Name** _________________________

REFERENCES: May be past employers, teachers, clergy, etc. Please do not use relatives and friends

REFERENCE I

Name____

Relationship to you __________________________________

Address____

Phone: Work____________________________**Home**___________________________

REFERENCE 2

Name____

Relationship to you ___________________________________

Address____

Phone: Work______________________________**Home**__________________________

HEALTH

Is there anything that may adversely affect your ability to perform volunteer work?_____

If yes, please explain ____

Are there any accommodations needed in order for you to safely and competently perform volunteer work as requested ? ___________

If yes, please explain ____

Do you have any physical, visual or hearing needs we need to consider? ______________
____

Are you physically able to transport patients? ____________________________________

When can you begin volunteering? ________________________

Please check all hospital areas you are interested in working:

} Admitting
} Education
} Emergency Room
} Gift Shop
} Greeter
} Hospital Events
} ICU Waiting Room
} Operating Waiting Room
} Patient Dismissal/ Flower Delivery, Etc.
} Patient Floors
} Other ____

Check when you wish to volunteer. Each shift is four hours.

( )	**Monday**	**morning** _________	**afternoon** _________
( )	**Tuesday**	**morning** _________	**afternoon** _________
( )	**Wednesday**	**morning** _________	**afternoon** _________
( )	**Thursday**	**morning** _________	**afternoon** _________
( )	**Friday**	**morning** _________	**afternoon** _________
( )	**Saturday**	**morning** ________	**afternoon** _________
( )	**Sunday**	**morning** ________	**afternoon** _________

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**___________