

TWIN CREEKS HOSPITAL VOLUNTEER APPLICATION

FOR INTERNAL USE ONLY

LAST NAME

FIRST NAME

DATE

APPLICANT INFORMATION

The following information is provided to assist you in accurate completion of this application for volunteer service.

- PLEASE ENSURE YOUR APPLICATION IS COMPLETE.
- If you become a volunteer at Twin Creeks Hospital, you will be required to permit the following at the hospital's expense:
 - Criminal background check
 - Provide routine health information and medical history in the unlikely event that you may require medical attention while on our premises
 - Tuberculosis Skin Test
- If you are offered and accept volunteer service, you agree to comply with all Twin Creeks Hospital policies and procedures, which will be explained to you in your Volunteer Handbook, and during volunteer orientation.
- All volunteer applicants are considered for volunteer service without regard to race/ethnicity, color, religion, sex, ancestry, national origin, age, marital status, disability or veteran status.

PERSONAL INFORMATION

Date of application: _____

Name: _____
First Middle Last

Address: _____
Street Apt # (if applicable)

City St Zip County

Home Telephone No. (____) _____ Email: _____

Cell/Other (____) _____

VOLUNTEER SCHEDULING PREFERENCES

Date available to begin volunteer service: _____

Please note that volunteer work will not be available prior to 7:30 am or after 8:00 pm.

Under each day of the week that you anticipate generally being available for volunteer work, please check the time(s) of day that you would prefer to volunteer:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
AM or PM	AM or PM	AM or PM	AM or PM	AM or PM	AM or PM	AM or PM

Any special notes or comments regarding your availability? _____

GENERAL QUESTIONS

Are you at least 16 years old? Yes No

Have you ever volunteered at or been employed by Twin Creeks Hospital? Yes No

If yes, what dates? _____

Do you have relatives currently employed with Twin Creeks Hospital? Yes No

Are you currently employed? Yes No

Have you been convicted of a felony? Yes No

If yes, please explain:

If applicable, please list special accommodations you may require in order to perform general volunteer service (if unsure, please request list of general volunteer duties): _____

Military service? Yes No

EXPERIENCE

Please describe specialized training skills, professional affiliations and other information that may assist us in identifying fulfilling volunteer assignments for you within our hospital: _____

Foreign Language Skills			
Language(s)	Proficiency Level		
	<input type="checkbox"/> Speak	<input type="checkbox"/> Read	<input type="checkbox"/> Write
	<input type="checkbox"/> Speak	<input type="checkbox"/> Read	<input type="checkbox"/> Write
	<input type="checkbox"/> Speak	<input type="checkbox"/> Read	<input type="checkbox"/> Write

The information given by me is certified to be true and complete, and may be verified by Twin Creeks Hospital or its designated representative. If I misrepresent information, or provide incomplete or false information, I understand and agree that I may be refused volunteer service.

I understand that Twin Creeks Hospital kindly requests a minimum commitment of one year of volunteer service from me. I also understand that despite any volunteer commitment I agree to, volunteer work with the hospital is at will, and a volunteer service arrangement between Twin Creeks Hospital and myself may be ended by myself or by the hospital at any time, with or without cause or notice.

Twin Creeks Hospital has my authorization to thoroughly investigate my criminal background, if any. I will hold no person liable for giving or receiving information in this investigation.

Social Security Number

Date of Birth

I have read and agree to the above.

Volunteer Applicant Signature

Date