STEPS TO VOLUNTEERING

Please read the following information carefully. It will explain the steps which must be completed prior to entering Volunteer Service at Memorial Hospital. In some cases, completion of all the necessary steps may take as long as a month or more. Any requirement may be more fully explained at the time of the personal interview.

COMMITMENT  Applicant must be 16 years of age, and have a serious intent to become a volunteer. Volunteers under the age of 18 years must complete a student application.

APPLICATION  Each applicant is asked to complete a written application form.

INTERVIEW  A private interview is arranged at that time or by telephoning the Volunteer Services Department 334-6609.

PHYSICIAN'S APPROVAL  A medical statement must be completed by the applicant’s family physician to verify physical well-being and emotional stability. The Volunteer Office will mail this form to your physician to complete. It is not necessary for the new volunteer to have a physical exam by their physician.

ORIENTATION  An orientation packet is given to each new volunteer. The packet contains information regarding hospital policy and procedure. This packet must be read and signed by the volunteer.

TRAINING  Training of the volunteer assignment is provided on the job by an employee or a senior volunteer.

ASSIGNMENT  Assignments are available throughout the hospital and may involve working with children or adults or require little or no patient contact. The Director of Volunteer Services works with the applicant to select an assignment which will best utilize the talents and interests of the volunteer.

EVALUATIONS  At the end of the first year and yearly there after, the volunteer has an opportunity to evaluate their job assignment. The department director also has an opportunity to evaluate the job assignment and the volunteer in that position.

BENEFITS  The hospital furnishes an identification badge and a smock or vest which must be worn whenever a volunteer is on duty. When on duty, a volunteer is entitled to a meal, courtesy of the hospital, and the volunteer can utilize the hospital pharmacy.

8/89 - Revised 7/93, 1/01, 9/02, 2/05, 1/06, 6/08, 11/08
APPLICATION FOR VOLUNTEER SERVICES

DATE: _______________________

NAME: ________________________________________________________________

(LAST)   (FIRST)   (MIDDLE)

ADDRESS: ________________________ CITY: ______ STATE: ______ ZIP: ______

BIRTH DATE (YEAR OPTIONAL): ____________ HOME PHONE: ____________ WORK PHONE: ______

IF PRESENTLY EMPLOYED, NAME OF FIRM: __________________________________________

POSITION: ________________________ WORK HOURS & DAYS: _______________________

CONTACT IN CASE OF EMERGENCY:

______________________________________________________________________________

(NAME)  (RELATIONSHIP)  (HOME PHONE)  (WORK PHONE)

FAMILY PHYSICIAN: ___________________________________________________________

OUT OF TOWN ADDRESS: _____________________________________________________

HOW DID YOU BECOME INTERESTED IN OUR VOLUNTEER PROGRAM?

______________________________________________________________________________

______________________________________________________________________________

HAVE YOU VOLUNTEERED FOR THIS ORGANIZATION BEFORE? _____ YES _____ NO

EDUCATION: ________________________________________________________________

VOLUNTEER EXPERIENCE: ____________________________________________________

WORK EXPERIENCE: _________________________________________________________

INDICATE HOBBIES/SKILLS/SPECIAL INTERESTS/FOREIGN OR SIGN LANGUAGE
SKILLS: ___________________________________________________________________

PLEASE GIVE ANY OTHER INFORMATION YOU FEEL PERTINENT TO YOUR
APPLICATION: ___________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

- OVER -

2/91, 7/93 Revised 1/01, Reviewed 9/02, 2/05, 1/06, 6/08
PERSONAL OR PROFESSIONAL REFERENCES (PLEASE EXCLUDE RELATIVES);

1. NAME:________________________________________ PHONE:_______________
   ADDRESS:________________________ CITY:________ STATE: ________ ZIP:______

2. NAME:________________________________________ PHONE:_______________
   ADDRESS:________________________ CITY:________ STATE: ________ ZIP:______

INTEREST/SKILLS: (Please indicate with a check mark which you would be willing to share as
a volunteer here.)

Clerical Skills:  _____typing _____filing_____phone receptionist_____using
   copier_____librarian
   _____record updating_____numerical updating_____computer_____mailing_____alphabetizing

Communication Skills:  ____public relations____tour guide____
   ____foreign language____other (specify:____________________________________________)

Additional
Skills/Comments:_______________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

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THE ABOVE INFORMATION IS ACCURATE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE:__________________________________________ DATE:__________________

YOUR SIGNATURE INDICATES YOUR APPROVAL FOR US TO CHECK REFERENCES
AND CONTACT YOUR PHYSICIAN REGARDING YOUR PHYSICAL AND EMOTIONAL
HEALTH. YOUR SIGNATURE DOES NOT OBLIGATE THE ORGANIZATION TO
PROVIDE A PLACEMENT, NOR ARE YOU OBLIGATED TO ACCEPT THE POSITION OFFERED.
OPPORTUNITIES FOR VOLUNTEERS ARE PROVIDED WITHOUT REGARD TO RELIGION, CREED, RACE, NATIONAL ORIGIN, AGE, SEX OR DISABILITIES.