



VOLUNTEER APPLICATION

Name _____ Phone Number _____

(Last Name, First Name, Middle Initial)

Home Address _____

Email address _____ Over 18 years of age ___ Yes ___ No

MOST RECENT EMPLOYMENT

Company _____ Dates Employed _____

Supervisor _____ Phone Number _____

Description of duties _____

VOLUNTEER EXPERIENCE

Organization _____ Dates _____

Direct Supervisor _____ Phone Number _____

Description of duties _____

Are you related to a Volunteer or Employee at Jones Memorial? ___ Yes ___ No

Name _____ Department _____

Please tell us why you would enjoy volunteering at Jones Memorial _____

Special area(s) or service of interest (*please place an X next to all that apply*)

Greet Visitors/Patients Transport Patients Alphabetizing Food Prep
 Wheelchair Assistance Stocking Typing Dishes
 Visit Patients Copying/Faxing Take/Make Calls Filing
 Cleaning Cashier Patient Assistant Mail Prep
 Deliver Mail/Flowers, etc Guide Visitors Bookkeeping

Do you have any physical limitations? Yes No

If yes, please explain _____

REFERENCES

Personal Reference:

1) Name: _____ Phone#: _____

Relationship _____

Professional References (no family or friends):

1) Name/Title: _____ Phone#: _____

Association: _____

2) Name/Title: _____ Phone#: _____

Association: _____

AGREEMENT

- ❖ I give the Jones Memorial Human Resource Office permission to contact my references.
- ❖ I understand that all hospital volunteers must follow New York State regulations for immunization screening and hospital orientation (Both **must** be updated yearly).
- ❖ I will consider all information I may gain, directly or indirectly, concerning a patient, physician, or any other person as **CONFIDENTIAL**.

By signing this agreement, I understand and accept the above statements and deem all information given on this application to be truthful.

Signature: _____

Date: _____