Decatur Morgan Hospital

ADULT VOLUNTEER APPLICATION

ALL INFORMATION WILL BE TREATED CONFIDENTIALLY.

Date of Application: _____ Date of Interview: _____

(to be completed by department director)

Please return application to: Community Relations Services, 1201 Seventh Street, SE, Decatur, Alabama 35601· decaturmorganhospital.net

(PLEASE PRINT)

Name:_____

Last ***First*** ***Middle Initial***

Address:_____

City:_____ **State**_____ **Zip:**_____

Phone:(256)_____ **Birthdate:**_____

month ***day*** ***year (optional)***

Cell Phone#_____

Email: _____

MILITARY SERVICE: _____Yes _____No

List hobbies/skills/special interests/foreign or sign language:

_____

_____

EDUCATION: (Circle) **(High School) 9 10 11 12 GED**

(College) 13 14 15 16 17 18 19

Have you ever been convicted of a felony? _____ Yes _____ No

If yes, describe:_____

_____

1975/revised June 2016

Have you participated in other community volunteer organizations?

_____ Yes _____ No

Where?

List duties:

Past employment:

List duties:

If presently employed, name of business:

May we contact the agencies and/or employers listed above?

_____ Yes _____No

REFERENCES: (not relatives)

Name/Occupation	Address	Phone

Volunteers may be required to have health tests which may include chest x-rays, skin tests and appropriate lab test that may be necessary as part of your volunteer services. If you are unwilling, please explain:

VOLUNTEER HOURS ARE USUALLY SCHEDULED IN 4 HOUR SHIFTS, ONE DAY A WEEK, BETWEEN THE HOURS OF 8 A.M. AND 4 P.M.

Please indicate the days you will be available: (Circle)

Mon. Tues. Wed. Thurs. Fri.

Hours Available: (Circle)

(Mon - Fri) 8 a.m. - 12 p.m., 9 a.m. - 1:30 p.m.

12 p.m. - 4 p.m.

SPECIAL SKILLS/INTERESTS

Check the items, in which you have abilities, or experience.

Please check all areas that you are interested in working in the hospital:

( ) Community Relations

( ) Escorts

( ) Food Services

( ) Gift Shop

( ) ICU Information Desk

( ) Information Desk

( ) Mammography

( ) Medical Plaza I Information Desk

( ) Patient Access Decatur Campus

Please give any other information you feel pertinent to your application:

How did you become interested in our program?

If selected as a hospital volunteer, on what date will you be available?

CONFIDENTIALITY STATEMENT

If chosen as a volunteer, I understand and agree that in the performance of my duties as a volunteer at Decatur Morgan. I must hold in strictest confidence any observations I may make or hear regarding patients, patients' families or hospital staff.

"I understand that intentional or involuntary violaton of confidentiality may result in disciplinary action, including termination, by Decatur Morgan."

SIGNATURE OF APPLICANT: _____

DATE: _____

"I certify that the information I have given is true and complete and that I have not knowingly witheld any information that would affect my application to serve as a volunteer. Anyone is hereby authorized to furnish Decatur Morgan any information concerning my character, habits, ability and prior record of employment at any time. Decatur Morgan is commited to equal opportunity for all applicants volunteering in the facility."

SIGNATURE OF APPLICANT: _____

DATE: _____

CONTACT IN CASE OF AN EMERGENCY:

NAME: _____

HOME PHONE: _____

CELL PHONE: _____

RELATIONSHIP: _____

ADDRESS: _____

PHYSICIAN: _____

PHYSICIAN PHONE NUMBER: _____

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