Decatur Morgan Hospital

# VOLUNTEEN 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, 1201 Seventh Street, SE, Decatur, Alabama 35601· www.decaturgeneral.org

**(PLEASE PRINT)**

**Name:**_____

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

**Address:**_____

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

**Phone:**_____ **Cell Phone:**_____

**Cell Phone Carrier: (Circle one ) ATT&T, Verizon, T-Mobile, Sprint, Other:** _____

**Birthdate:**_____

**Email:** _____

**SCHOOL NOW ATTENDING**_____

**GRADE CURRENTLY COMPLETED**_____ **GRADE POINT AVERAGE**_____

**Are you interested in a health career?** _____ **If yes, which?**_____

**Other reason (s) why you are interested in being a volunteen:**

_____

_____

_____

**Will your summer schedule permit you to complete the 10 week program, other than time away for summer vacation?** _____**Yes** _____**No**

**If no, please explain.**_____

_____

**Have you participated in other community volunteer organizations?** _____**Yes** _____ **No**

**If yes, Where**_____

**List duties**_____

**How did you become interested in our volunteen program?**

_____

_____

**1975**
**Reviewed/Revised June 2016**

**Please see other side**

## SPECIAL SKILLS/INTERESTS

Please check three areas that you are interested in working in the hospital and number them in the order of your first, second or third choice:

( ) Community Relations Decatur Campus
( ) Emergency Room Decatur Campus
( ) Emergency Room Parkway Campus
( ) Food Services Decatur Campus
( ) New Born Center Parkway Campus
( ) PACU Decatur Campus
( ) Patient Access Decatur Campus
( ) Patient Access Parkway Campus
( ) Pre-Admission Testing Decatur Campus
( ) Respiratory Therapy Decatur Campus & Parkway Campus
( ) Rehab Access Danville Road Campus

DAYS AVAILABLE: (CIRCLE) M T W T F

**Volunteens needed for:**
**Weekdays:** Between 8 a.m. and 2 p.m.

**I UNDERSTAND THAT AS A DECATAUR MORGAN HOSPITAL VOLUNTEEN, I WILL NOT RECEIVE PAY FOR MY SERVICES.**

_____
Signature of Applicant

**NOTIFY IN CASE OF AN EMERGENCY:**

NAME:_____

ADDRESS:_____

PHONE:H_____Cell: _____

FAMILY DOCTOR:_____Phone_____

**FOR PARENT TO COMPLETE**

Do you object to your child having a tuberculin skin test? _____Yes _____No

**Parental Consent:**
We/I hereby agree to allow our daughter/son to serve as a volunteen at Decatur Morgan Hospital. We fully understand that in the course of duties our daughter/son will be permitted to enter patient areas and/or patient rooms. We understand that as a volunteer our daughter/son will not receive pay for services given to the hospital.

Date_____ Parent or Legal Guardian_____

## CONFIDENTIALITY STATEMENT

If chosen as a volunteer, I understand and agree that in the performance of my duties as a volunteer at Decatur Morgan Hospital. 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.

Volunteer Signature_____ Date_____

**DO NOT WRITE BELOW THIS DOTTED LINE**

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Date Interviewed:_____ Interviewed By_____

Comments:_____

_____

**1975**
**Reviewed/Revised February 2017**