

Name \_\_\_\_\_ Nickname \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Last) (First) (Middle)

Street Address: \_\_\_\_\_ Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
City/State/Zip

Email Address: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Circle: Home – Cell – Work

Secondary phone \_\_\_\_\_ Emergency Contact: \_\_\_\_\_  
Circle: Home – Cell – Work Name/Phone Number/Relationship

Gender:  Male  Female Marital Status:  Single  Married

Ethnic Origin:  Asian  American Indian or Alaskan  Hispanic or Latino  
 Caucasian  Native Hawaiian or Other Pacific  Two or more  Black or African American

Country of Citizenship: \_\_\_\_\_ Eligible to work in the U.S.:  Yes  No

**Please explain your motivation for volunteering:**

\_\_\_\_\_

**Please prioritize your top 3 reasons for wanting to volunteer, with #1 being most important:**

\_\_\_Community involvement \_\_\_Socialization \_\_\_Retired \_\_\_School Requirement \_\_\_Former patient  
\_\_\_Networking \_\_\_Experience \_\_\_Career exploration

**Why did you choose St. Vincent for your volunteer service?**

\_\_\_\_\_  
\_\_\_\_\_

**Length of time you are willing to commit to volunteering:**

Less than 6 months  6 months to a year  1 to 2 years  2 + years

**How did you hear about our volunteer program?**

Volunteer or employee referral \_\_\_\_\_  
Name of person referring

Community Event  School  Newspaper  Internet  Other: \_\_\_\_\_

**Work Experience:**

Are you currently employed \_\_\_Yes \_\_\_No

If yes, name of employer \_\_\_\_\_ Position/Title \_\_\_\_\_

If no, please tell us about your last position held:

Name of Business \_\_\_\_\_ Position/Title \_\_\_\_\_

Reason for leaving \_\_\_\_\_

Are you currently looking for a job \_\_\_\_ Yes \_\_\_\_ No

**Education:** Please circle all that apply:

Current Student: **yes / no** Attend or Graduate - High School: **yes / no** Attend or Graduate - College: **yes / no**

Name of High School Attended: \_\_\_\_\_ Name of University: \_\_\_\_\_

**Military Status:**

Have you ever been a member of any branch of the military? \_\_\_\_\_ If Yes, what branch? \_\_\_\_\_

Beginning Date of Service: \_\_\_\_\_ Ending Date of Service: \_\_\_\_\_

**Interest/Skills: (please indicate with a check mark all that apply):**

Volunteer Opportunities	<input type="checkbox"/> Shuttle Driver <input type="checkbox"/> Patient Escort and Guest Services <input type="checkbox"/> Musician <input type="checkbox"/> Interpreter <input type="checkbox"/> Flower/Mail Delivery <input type="checkbox"/> Emergency Dept. <input type="checkbox"/> Pet Therapy <input type="checkbox"/> Clerical <input type="checkbox"/> Data Entry <input type="checkbox"/> Gift Shoppe sales asst. <input type="checkbox"/> Nursing unit asst. <input type="checkbox"/> Hospitality Services <input type="checkbox"/> Reading to Pts. <input type="checkbox"/> Other (specify)
Additional Skills or comments	

**Personal References:**

Name	Title/Position	Phone Number

What is your availability: day(s) of week \_\_\_\_\_ time: Morning Afternoon Evening

Are you interested in joining the Auxiliary: yes \_\_\_\_/no \_\_\_\_

I hereby authorize former or current employers (except those noted in writing) as well as all personal references, churches and schools to provide any verification they have regarding me or my employment with them to a representative of Volunteer Services, Human Resources or other related hospital officials. I further understand that as a volunteer, I am not eligible for and have no expectation of receiving compensation or medical benefits, including workers compensation.

I authorize Volunteer Services in conjunction with Human Resources to request a criminal history background check as related to my volunteer duties.

I hereby certify that all information given in this application is true and correct. I hereby give my permission to St. Mary's Medical Center to investigate the information given above. I agree to abide by the rules, policies, and procedures of St. Mary's Medical Center.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Thank you for your interest in becoming a volunteer. After completion of this application you will be contacted for an interview. You will be placed in an area of service based on need and availability.

**St. Mary's Medical Center**

**Volunteer Health Information Form**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Do you have a current medical condition that St. Mary's should be aware of? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please explain the condition: \_\_\_\_\_

Do you have any allergies ie: latex, medications, etc., that you are aware of? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please explain \_\_\_\_\_

Do you have a contagious disease? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, please explain the nature of the

illness: \_\_\_\_\_

Have you been immunized against any or diagnosed with any of the following?

Rubella \_\_\_\_\_ Yes \_\_\_\_\_ No

Mumps \_\_\_\_\_ Yes \_\_\_\_\_ No

Measles \_\_\_\_\_ Yes \_\_\_\_\_ No

Hepatitis A \_\_\_\_\_ Yes \_\_\_\_\_ No

Chickenpox \_\_\_\_\_ Yes \_\_\_\_\_ No

Hepatitis B \_\_\_\_\_ Yes \_\_\_\_\_ No

PLEASE NOTE: All volunteers must provide proof of immunizations or consent to additional screenings.

PLEASE NOTIFY IN CASE OF EMERGENCY:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

If unavailable contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

**I hereby certify that the above information is true and accurate to the best of my knowledge:**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_