OFFICE USE ONLY

❑ Interview	Address Card ❑
❑ Orientation	Welcome Letter ❑
❑ Confidentiality Statement	Handbook Received ❑
❑ Data Entry	Name Tag ❑
❑ Corporate Mailing List	Health Release ❑

ADULT VOLUNTEER APPLICATION FORM

This application must be completed in its entirety.

Date ___________________________

PERSONAL DATA

Name ____
Last First Middle

Date of Birth ______________________ Social Security Number ______________________
Month Day (Year Optional)

Address ____ Zip ______________

Home Phone ______________________ Work Phone ______________________

E-mailAddress______________________________ Alternative Number______________________

Spouse's Name ____

In case of an emergency, notify: Name ______________________Relationship ______________

Home Phone ______________________Work Phone______________________

Have you ever been convicted of or pled guilty to a felony or misdemeanor other than a minor traffic violation? If yes, explain:

____

PERSONAL REFERENCES

List two personal references who **are not** related to you. **Do Not** list former employers:

____
(name) (address) (phone) (company/relationship) (yrs. known)

____
(name) (address) (phone) (company/relationship) (yrs. known)

SCHEDULE

(Check the day(s) when you are available to do volunteer work.)

❑ Monday ❑ Tuesday ❑ Wednesday ❑ Thursday ❑ Friday ❑ Saturday ❑ Sunday

HOURS

(Please check) ❑ Morning 8 - 12 ❑ Afternoon 12 - 4 ❑ Evenings 4 - 8

FREQUENCY

(Please check) ❑ Weekly ❑ Biweekly ❑ Monthly

TRANSPORTATION

Do you have a current Indiana Driver's License? ❑ Yes ❑ No

Do you have your own transportation? ❑ Yes ❑ No

PHYSICAL and MEDICAL BACKGROUND

Do you have a condition which would prevent you from performing the essential functions of your Volunteer Service position? ❑ Yes ❑ No If yes, explain ______________________________________

____

____

____

Family Physician______________________________________Phone________________

JOB, VOLUNTEER, OR COMMUNITY SERVICE EXPERIENCE

List below all present and past employment or volunteer experience beginning with your most recent. Be sure to include previous employment with Saint John's Health System and any military experience.

EMPLOYMENT HISTORY - Present Position First And Your Name During Employment

COMPANY	FROM MO	FROM YR	TO MO	TO YR	TITLE AND DUTIES	SUPERVISOR'S NAME	REASON FOR LEAVING
NAME STREET CITY/STATE ZIP PHONE						 Your Name At That Time	
NAME STREET CITY/STATE ZIP PHONE						 Your Name At That Time	

COMMUNITY AFFILIATIONS

					NATURE OF VOLUNTEER WORK	SUPERVISOR'S NAME
NAME STREET CITY/STATE ZIP PHONE						 Your Name At That Time

RECORD OF EDUCATION

SCHOOL	NAME AND ADDRESS OF SCHOOL	DATES ATTENDED FROM	DATES ATTENDED TO	LAST YEAR COMPLETED	DID YOU GRADUATE?	DIPLOMA OR DEGREE REC'D.	SUBJECT OF SPECIALIZATION
HIGH SCHOOL							
COLLEGE/ UNIVERSITY							
NURSING SCHOOL							
SPEC. TRAINING/ TECH. SCHOOL							
OTHER EDUCATION							

PROFESSIONAL LICENSURE INFORMATION (If Applicable)

STATES REGISTERED	LICENSE NUMBER	DATE ISSUED	EXPIRATION DATE
____________	____________	____________	____________
____________	____________	____________	____________

Has your registration ever been cancelled? ❑ Yes ❑ No

If Yes, explain ____

____

____

____

SERVICE SKILLS

Are there any experiences, skills or qualifications which you feel would especially fit you for volunteer work with Saint John's? If yes, please check those below that apply/or write in specific skills:

HEALTH CARE SKILLS

- ❑ RN
- ❑ LPN
- ❑ PA, QMA, EMT
- ❑ CPR/First Aid Trained
- ❑ Medical Terminology
- ❑ Other (Specify)________________________

HOMEMAKER SKILLS

- ❑ Cooking
- ❑ Cleaning
- ❑ Laundry
- ❑ Mending/Sewing
- ❑ Couponing/Shopping

VISITATION/RESPITE

- ❑ Conversation
- ❑ Cards/Board Games
- ❑ Reader/Letterwriter

HOBBIES

- ❑ Crafts
- ❑ Handwriting
- ❑ Singing

HANDI SKILLS

- ❑ Carpentry
- ❑ Plumbing
- ❑ Electrical
- ❑ Heating/Cooling
- ❑ Architecture/Engineering
- ❑ General Contractor
- ❑ Painting/Plastering
- ❑ Gardening/Yard Work

CHILD CENTERED SKILLS

- ❑ Tutor/Adopt-A-School______________________
- ❑ Reading/Language
- ❑ Math
- ❑ History/Soc. Studies
- ❑ Science
- ❑ Music/Drama
- ❑ Arts/Crafts
- ❑ Other (Specify)_________________________

____

Do you prefer to work:

- ❑ One on One
- ❑ Small Groups
- ❑ With Children (specify ages)_____________
- ❑ With older Adults

CLERICAL

- ❑ Cash Register
- ❑ Calculator
- ❑ Receptionist, Hostess
- ❑ Typing
- ❑ Word Processing
- ❑ Filing
- ❑ Mailroom
- ❑ Transporting Materials
- ❑ Bookkeeping
- ❑ Wheelchair Transport
- ❑ Library

OTHER

- ❑ Fundraising
- ❑ Tour Guide
- ❑ Manning Booths
- ❑ Community Events
- ❑ Chaplaincy Services
- ❑ Special Functions
- ❑ Ticket Sales

Additional information or comments:

CERTIFICATE OF APPLICANT

PLEASE READ CAREFULLY

The facts contained in this application for volunteer work are true and complete. I understand that if I became a volunteer, any false statements on this application will be cause for release from the program.

I authorize Saint John's Health System to contact my current and/or former employers or volunteer agencies and any other person who may have information bearing on my suitability for volunteer work. I further understand that a criminal history check may be completed in compliance with Indiana law. I authorize information to Saint John's Health System pertaining to my qualifications, past work experience, work performance, employment status, character, behavior and any other information related to my work history and/or suitability for volunteering. I agree that all questions asked and information released in good faith shall be privileged, and I expressly release Saint John's, such employer, such other persons and any of their authorized representatives from any and all liability arising from questions asked, information released, or statements made in good faith.

AGREEMENT: I agree to adhere to my volunteer responsibilities as stated in the Volunteer Handbook.

Signature: ____ Date: _______________

All volunteers working at Saint John's are requested to have annual tuberculosis tests provided free of cost by our Associate Health Nurse. If you had a chest x-ray or TB test within the past 12 months, please list date:

____

FOR INTERVIEW INFORMATION

Date called for appointment ___________ **Date of appointment** _________ **Time** _______

Position to train for ____

When to start: Date ____________ **Time** ____________