

**ADULT and
COLLEGE 18 & OLDER**



VOLUNTEER SERVICES APPLICATION

CONFIDENTIAL

PERSONAL INFORMATION

First _____ Middle _____ Last _____

Date of Birth _____ Social Security # _____

Driver's License # _____

Email _____

Address _____

City _____ State _____ Zip _____

Phone _____ Secondary Phone _____

Do you speak any foreign languages? [] No [] Yes- If yes, please list. _____

EMERGENCY INFORMATION

Emergency Contact _____

Relationship to you _____ Home Phone _____

Work Phone _____ Cell Phone _____

QUESTIONNAIRE

1. Why are you interested in volunteering? _____

2. Are you currently seeking volunteer experience to fulfill a community service obligation (i.e. church, school)? No [] Yes [] – If yes, please describe the service requirements _____

Service Organization & Contact _____

Phone Number _____

3. Is there anything that may adversely affect your ability to perform volunteer work? No [] Yes [] – **If yes, please describe in detail** _____

4. Are there any accommodations needed in order for you to safely and competently perform volunteer work as requested? _____

5. Do you have any physical, visual or hearing needs we need to consider?
No [] Yes [] – **If yes, please explain:** _____

6. Are you physically able to transport patients? Yes [] No []

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

- | | |
|--|--|
| <input type="checkbox"/> American Cancer Society Resource Center at Deaconess Medical Center | <input type="checkbox"/> Patient Care Floors |
| <input type="checkbox"/> Cardiac Intensive Care Desk | <input type="checkbox"/> Pharmacy |
| <input type="checkbox"/> Day Surgery | <input type="checkbox"/> Radiology |
| <input type="checkbox"/> Emergency Department | <input type="checkbox"/> Short Stay |
| <input type="checkbox"/> Gift Shop | <input type="checkbox"/> Surgery Liaison Desk |
| <input type="checkbox"/> Guest Relations | <input type="checkbox"/> Tours |
| <input type="checkbox"/> ICU Intensive Care Desk | <input type="checkbox"/> Volunteer Services Office Support |
| <input type="checkbox"/> Mailroom | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Medical Records | _____ |
| <input type="checkbox"/> Mother Baby | _____ |
| <input type="checkbox"/> Osteoporosis/Blood Pressure Screening | _____ |

OTHER:

1. Have you ever been convicted of a felony? Yes [] No []

2. Have you ever been convicted of a misdemeanor? Yes [] No []

If 'Yes' to either question, please describe the conviction(s) in detail, including dates.

EDUCATION & WORK EXPERIENCE

Education: Check highest level

High School: 9 [] 10 [] 11 [] 12 [] GED []

Name & State _____

If a college student 18 and older, please list your primary interest of study/career goals

College: 1 [] 2 [] 3 [] 4 [] Graduate School 1 [] 2 [] 3 [] 4 []

Degree/Major _____

Employment Experience:

Have you ever worked at a hospital? Yes [] No []

Last Place of Work – if any: _____

Business Name _____

Address _____ Phone _____

Position _____ Supervisor’s Name: _____

REFERENCES:

Please include references for any current or former job supervisors, teachers or clergy. Family members, relatives and friends may not provide recommendations.

Reference 1 Name: _____ Phone: _____

Relationship to you: _____ Business Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Reference 2 Name: _____ Phone: _____

Relationship to you: _____ Business Name: _____

Address: _____ City: _____ State: ____ Zip: _____

COLLEGE STUDENTS ONLY: INCLUDE WITH YOUR APPLICATION

- **A letter of reference from a COLLEGE PROFESSOR with your completed application IN LIEU OF A SECOND REFERENCE.**
- **An UNOFFICIAL copy of your college transcripts.**

3. How did you hear about this volunteer program? _____

5. When can you start volunteering? _____

6. Check when you are available to volunteer. Each shift is 4 hours**

- | | | | |
|------------------------------------|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> Monday | _____ 8:00 am – 12:00 pm | _____ 12:00 pm – 4:00 pm | _____ 4:00 pm – 8:00 pm |
| <input type="checkbox"/> Tuesday | _____ 8:00 am – 12:00 pm | _____ 12:00 pm – 4:00 pm | _____ 4:00 pm – 8:00 pm |
| <input type="checkbox"/> Wednesday | _____ 8:00 am – 12:00 pm | _____ 12:00 pm – 4:00 pm | _____ 4:00 pm – 8:00 pm |
| <input type="checkbox"/> Thursday | _____ 8:00 am – 12:00 pm | _____ 12:00 pm – 4:00 pm | _____ 4:00 pm – 8:00 pm |
| <input type="checkbox"/> Friday | _____ 8:00 am – 12:00 pm | _____ 12:00 pm – 4:00 pm | _____ 4:00 pm – 8:00 pm |
| <input type="checkbox"/> Saturday | _____ 8:00 am – 12:00 pm | _____ 12:00 pm – 4:00 pm | _____ 4:00 pm – 8:00 pm |
| <input type="checkbox"/> Sunday | _____ 8:00 am – 12:00 pm | _____ 12:00 pm – 4:00 pm | _____ 4:00 pm – 8:00 pm |

***Times may vary depending on your department placement*

Certification and Authorization

PLEASE READ THE FOLLOWING BEFORE SIGNING:

Your placement as a volunteer with Deaconess Medical Center is dependent upon the acceptance by Volunteer Services and completion of the hospital health requirements along with a criminal background screening and drug screening. The purpose of these screenings is for the protection of patients, staff, physicians and volunteers.

I certify that the information I have provided is true and complete to the best of my knowledge. I understand that misrepresentation, falsification, or omission of information may disqualify me from further consideration for volunteering, or may result in my termination as a volunteer.

I authorize the Hospital to investigate all statements contained in this application and to make inquiries of my personal references and medical history, as well as other related matters as may be necessary for determining my eligibility as a volunteer. I further understand that my volunteering is contingent upon checking of references furnished. I hereby release physicians, employers, schools or individuals from all liability in responding to inquiries relating to my volunteer application.

I understand I will not be paid for my volunteer services and if accepted as a volunteer, I understand that I must abide by all of the policies, rules and regulations of the Hospital.

COLLEGE STUDENTS: PLEASE INCLUDE A COPY OF YOUR IMMUNIZATION RECORDS WITH YOUR APPLICATION.

Name: _____

Date: _____

PLEASE MAIL OR FAX YOUR COMPLETED APPLICATION TO:

**Deaconess Medical Center
VOLUNTEER OFFICE
800 West Fifth Ave.
Spokane WA. 99210-0248**

**FAX NUMBER – 509-473-3148
Office – 509-473-3058
509-473-3767**