JENNIE EDMUNDSON HOSPITAL
An Affiliate of Methodist Health System

VOLUNTEER APPLICATION Date _____ ❒ Adult ❒ Teen ❒ Special Events Vol #:_____

Last Name: _____ First Name: _____ Middle Name: _____ Birth Month/Day/Year: ____-___-___
Address: _____ City/State/Zip: _____
Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____ E-Mail Address: _____
Year-Round Resident? ❒ Yes ❒ No If no, list available months_____
Emergency Contact: _____ Relationship: _____
Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____ Work Phone: (____) _____ - _____

Are you currently a student? ❒ Yes ❒ No **If yes,** where? _____

Previous Volunteer or Paid Employment Experience: _____

Hobbies, Skills, or Special Interests: _____

Have you volunteered at Jennie Edmundson Hospital in the past? ❒ Yes ❒ No **If yes,** when and in what capacity? _____

How were you referred to Jennie Edmundson Hospital? _____

Have you ever been convicted of a misdemeanor or felony? ❒ Yes ❒ No **If yes,** please explain: _____

Do you need verification of your Jennie Edmundson Volunteer hours for a requirement? ❒ Yes ❒ No **If yes,** where, and why?

_____ Contact person: _____

Are you fluent in any language(s) other than English? ❒ Yes ❒ No **If yes,** which one(s)? _____

Indicate Preferred Days & Hours

	M	*T*	*W*	*TH*	*F*	*SAT*	*SUN*
Morn							
Aft							
Eve							

Volunteer Areas of Interest: *(✓ all that apply)*

❒ *Lobby / Information Desks / Waiting Rooms*	❒ *Office Work*	❒ *Emergency Department*
❒ *Gift Shop / Pharmacy Annex*	❒ *Fundraising / Special Events*	❒ *Other: Mentoring / Sewing*

VOLUNTEER STATEMENT: I wish to donate my services to Jennie Edmundson Hospital and understand there is no payment for services rendered as a volunteer at Jennie Edmundson Hospital. I understand that any false or incomplete statements on this application or any other form that I complete shall be sufficient cause for rejection for volunteering or immediate discharge when discovered. I understand that the Hospital and Volunteer Staff may take photographs of me for publications or other uses. I agree to abide by the rules, regulations and policies of the Hospital department in which I serve and Volunteer Services Department. I further understand confidentiality must be maintained concerning patient and family information. I understand that if I do not abide by the Hospital Department and Volunteer Services Department rules, regulations and policies, that I will be terminated from the volunteer program. Effective November 2006, Methodist Health System has adopted a tobacco free policy on all campuses. I understand if I am accepted as a Volunteer, it may be contingent on successfully passing a post offer drug test. Some affiliates require criminal background checks. Some positions require various registry checks, as well.

Volunteer Signature: _____ Date: _____