

PLEASE PRINT

Today's Date: _____

Name: _____**Address:** _____
Street City State Zip**Home Phone:** _____ **Cell Phone:** _____**Email:** _____
For Volunteer Services use only.**Emergency Contact:** _____ **Phone:** _____
Name/RelationshipSpecial training, skills, or interests: _____
_____Do you speak a foreign language? ☐ No ☐ Yes; explain: _____Community Affiliations: _____
_____**Referred by (name):** _____ **Phone:** _____**Personal Reference (name):** _____ **Phone:** _____**Address:** _____
Street City State Zip**Area(s) of Volunteering Interest:**

- ☐ Patient Services (Reception/Escort, Respite Care, "Lend an Ear" Volunteer, etc.)
- ☐ Community Outreach (Tele-Care Callers, Blood Drives, Diabetes Education Support Group, Appointment Reminder Calls, Cancer Support Group, etc.)
- ☐ Fundraising (Holiday Tea, Love Light Program, Vendor Sales, etc.)
- ☐ Other (Office Work, Telephoning, Knitting, Sewing, Cardmaking, etc.)
- ☐ Committee (Orientation, Scholarships, etc.)

Days of the Week Available: _____

Times of the Day Available: _____

Reason for Volunteering: _____

How did you hear about our Volunteer Program? _____

I understand and agree that at no time will any information regarding patients be revealed to anyone other than those authorized to receive it. I understand that the giving of the information concerning a patient to those not authorized to receive information is unlawful and shall be sufficient cause for my immediate dismissal.

I agree to any necessary health screening required and understand my volunteer assignment is contingent upon successful completion of this screening, completing any necessary immunizations, and attending orientation.

I understand that any false statements made as a part of this application may be considered sufficient cause for dismissal.

I authorize permission for all named references and educational institutions to release personal and professional information to the Volunteer Services office. I also consent to an annual police record search and a Department of Motor Vehicles check. I further release Black River Health, Black River Falls, WI, as well as those supplying said information from any and all liability from these investigations.

I UNDERSTAND THAT IF ACCEPTED AS A VOLUNTEER I WILL ABIDE BY THE GENERAL POLICY CONCERNING CONFIDENTIALITY. My assignment is on a probationary basis for a period of 70 days. I voluntarily offer my services with a clear understanding that there is no monetary compensation. I will observe all mandatory regulations.

Applicant Signature

Date

FOR VOLUNTEER SERVICES TO COMPLETE

Interview Date: _____ Date Application Received: _____