VAL VERDE REGIONAL MEDICAL CENTER

VOLUNTEER APPLICATION

PERSONAL INFORMATION

NAME: _____
Last **First** **M.I.**

ADDRESS: _____
Street **City/State** **Zip**

PHONE: _____ **EMAIL ADDRESS** _____

EMERGENCY CONTACT INFORMATION

Name **Phone Number** **Relationship**

HAVE YOU EVER PLED GUILTY OR NO CONTEST TO AND/OR BEEN CONVICTED OF ANY CRIME, FELONY OR MISDEMEANOR, OTHER THAN A TRAFFIC CITATION? ☐ NO ☐ YES (MUST PROVIDE DETAILS)
Details:

ARE YOU AT LEAST 18 YEARS OF AGE? ☐ YES ☐ NO	ARE YOU LEAGALLY ELIGIBLE FOR EMPLOYMENT IN THE UNITED STATES? ☐ YES ☐ NO	HAVE YOU EVER BEEN EMPLOYED BY VVRMC OR ITS AFFILIATE CLINICS? ☐ NO ☐ YES WHERE:
WHAT ARE YOUR VOLUNTEER INTERESTS?	☐ Auxiliary ☐ Hospice ☐ Chaplaincy ☐ HOPE Cancer Room ☐ OTHER_____	
PLEASE DESCRIBE WHY YOU ARE INTERESTED IN VOLUNTEERISM AT VVRMC?		
ARE YOU VOLUNTEERING TO COMPLETE A PROGRAM OR COURSE OF STUDY?	☐ NO ☐ YES (Must provide details and attach documentation) Details:	
PLEASE LIST SKILLS, SPECIAL TRAINING, OR FOREIGN LANGUAGES YOU POSESS.		

WHAT HOURS AND DAYS ARE YOU ABLE TO VOLUNTEER?	SUN.	MON.	TUE.	WED.	THURS.	FRIDAY	SAT.

PLEASE PROVIDE PREVIOUS EMPLOYMENT OR VOLUNTEER WORK.	EMPLOYER	DATES	SUPERVISOR NAME
	EMPLOYER	DATES	SUPERVISOR NAME

PLEASE PROVIDE 3 REFERENCES WHO ARE NOT RELATIVES.	NAME	PHONE
	NAME	PHONE
	NAME	PHONE

I understand that willfully making false statements on this application will be sufficient cause for non-placement in volunteer service and or grounds for immediate dismissal. I authorize VVRMC to check any references listed on this application in addition to any additional background, drug and health screening. I understand that this application does not bind me or VVRMC for any specific period regarding volunteerism. I understand that my services are donated to the hospital without contemplation of compensation or future employment. I am responsible for attending any orientation and familiarizing myself with VVRMC's policies and procedures.

_____ _____
SIGNATURE OF APPLICANT DATE

OVER FOR AUTHORIZATION

AUTHORIZATION (FOR INTERNAL USE ONLY)

ACTIONS	RECOMMENDED VOLUNTEER AREA	START DATE
☐ SELECTED ☐ NOT SELECTED	☐ Auxiliary ☐ Hospice ☐ Chaplaincy ☐ HOPE Cancer Room ☐ OTHER_____	
SUPERVISOR/COORDINATOR SIGNATURE TO PROCEED		**DATE**

HR CHECKLIST

☐ APPLICATION
☐ INTERVIEW
☐ DRUG/BACKGROUND AUTHORIZATION
☐ DRUG SCREEN INITIATED
☐ BACKGROUND SCREEN INITIATED
☐ DRUG SCREEN CLEARED
☐ BACKGROUND SCREEN CLEARED
☐ HEALTH SCREENING/TB CLEARED
☐ NOTIFY VOLUNTEER COORDINATOR(S) TO PICK UP PACKET

VOLUNTEER COORDINATOR(S) CHECKLIST

☐ ORIENTATION SCHEDULED
☐ ORIENTATION COMPLETE – CLEAR TO START