VOLUNTEER SERVICES APPLICATION

South Arkansas Regional Hospital
in collaboration with UAMS Health

PERSONAL INFORMATION

First _________________________ Middle _________________ Last ______________________

Date of Birth __________________________ Social Security # ___________________________

Driver's License # ______________________ Photo Copy [ ] Yes [ ] No

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 ____

EDUCATION & WORK EXPERIENCE

Level of education, please specify ____

If under 18, please list your primary interest of study/career goals ____________________

____

____

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: ______

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.

____

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 in a wheelchair? Yes [ ] No [ ]

7. Please check all areas that you are interested in working as a volunteer:

[ ] Information Desk
[ ] Gift Shop
[ ] Pharmacy
[ ] One Day Surgery
[ ] Outpatient Registration
[ ] ICU Waiting Room

8. How did you hear about this volunteer program? ___________________________

____

9. Do you hold any special medical or clinical certifications or licenses, or had medical training of any type? No [ ] Yes [ ] – Please list: ______________

____

10. When can you start volunteering? __________________________________

Please list your Jacket Size___________

11. Check when you wish to volunteer. Each shift is 4 hours.

[ ] Monday ___________________to ________________________
[ ] Tuesday __________________ to ________________________
[ ] Wednesday ________________to ________________________
[ ] Thursday __________________to ________________________
[ ] Friday ____________________ to ________________________
[ ] Saturday __________________ to ________________________
[ ] Sunday ___________________ to ________________________

Certification and Authorization

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.

If accepted as a volunteer, I understand that I must abide by all of the policies, rules and regulations of the Hospital.

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 hereby release physicians, employers, schools or individuals from all liability in responding to inquiries relating to my volunteer application.

Name: ____

Date: ____

Please return the completed form using one of the below options:

Mail
South Arkansas Regional Hospital
Attn: Auxiliary
700 West Grove Street
El Dorado, AR 71730

In person
Gift Shop: Hospital front entrance, third door on your right.

Email
cindy.grimmett@mcsaeldo.com