VOLUNTEER APPLICATION

Date**: _____**

Last Name**: _____** First Name: _____

Phone**: _____** Email**: _____**

Address**: _____**

Birth Date**: _____** How many months can you volunteer**: _____**

We require a minimum of 100 hours within a 12 month period to become a volunteer

Do you authorize the Volunteer Program to add your contact information to the volunteer list?

□ Yes   □ No

Do you agree to have your photo taken and used for recruitment, recognition and/or other official Volunteer Program uses?

□ Yes   □ No

Presently Employed?   □ Yes □ No   Employer: _____

Education/Training/Foreign Language: _____

Previous Volunteering Experience**: _____**

_____

Have you ever been accused, disciplined, found guilty or convicted of any type of harassment, violence, or infraction involving dishonesty or financial impropriety in the workplace? □ Yes   □ No

If YES, explain: _____

Have you ever been convicted or entered into a plea bargain for a crime? □ Yes   □ No

If YES, explain: _____

If you have any questions, please email volunteer@mvhospital.net or call/text 208-569-7589.

REFERENCES

Name: _____ **Relationship:** _____ **Phone:** _____

Name: _____ **Relationship:** _____ **Phone:** _____

TIME AVAILABILITY

Our shifts range from 2-4 hours, please indicate which days you would be available to volunteer and the time frame expected by circling AM or PM under the appropriate day.

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	WEEKENDS
AM PM	AM PM	AM PM	AM PM	AM PM	AM PM

ACTIVITY LEVEL

☐ High (able to walk long distances, walk frequently, pushing wheelchairs, stairs, lifting)

☐ Moderate (able to walk short distances and in spurts, light lifting)

☐ Light (mostly sitting with limited walking)

Emergency Contact: _____ **Phone:** _____

I understand I must submit to both a reference and background check as well as a medical screening through Employee Health for the purpose of determining volunteer status. I will commit to volunteer 2-4 hours each week with the goal of reaching at least 100 hours within a 12 month period. If I do not meet this requirement, I understand that no letter of recommendation will be issued for my services. I understand that it is my responsibility to read and follow MVH - IFCH rules/regulations and volunteer description for my assignment. I will perform my duties to the best of my ability.

By signing below you are confirming that the above information is true to the best of your knowledge.

SIGNATURE: _____ **DATE:** _____

Once your application is submitted, you will receive an email with attached legal forms and orientation to complete, please follow all instructions.

If you have any questions, please email volunteer@mvhospital.net or call/text 208-569-7589.