



Southern New Hampshire Medical Center

ADULT VOLUNTEER SERVICES APPLICATION

You must be willing to get a yearly flu shot to volunteer.

NAME: _____ HOME _____ DATE _____
TEL: _____ CELL# _____

EMAIL ADDRESS: _____ DATE OF BIRTH _____

ADDRESS: _____ CITY _____ ST _____ ZIP _____

WORK EXPERIENCE: _____

EDUCATION & TRAINING _____

PREVIOUS VOLUNTEER EXPERIENCE: _____

EMERGENCY CONTACT: _____
(Name) (Relationship) (Home Phone) (Work Phone)

HAVE YOU EVER BEEN CONVICTED OF A FELONY? ___ YES ___ NO. IF YES, GIVE DATE AND DETAILS.

HAVE YOU BEEN CONVICTED OF A MISDEMEANOR WITHIN THE LAST FIVE YEARS? ___ YES ___ NO. IF YES EXPLAIN

References: Any adult who is not a relative
REFERENCES:

1. _____ email _____

2. _____ email _____

WHY DO YOU WANT TO VOLUNTEER? _____

SPECIFY VOLUNTEER SERVICE AREAS OF INTEREST: _____

DAYS AND HOURS AVAILABLE TO VOLUNTEER: _____

PLEASE SIGN BACK OF THE FORM

To be filled out by Volunteer Director

Reference _____ OIG _____ Criminal Background _____ Orientation _____ TB _____ Flu Shot _____
eboarded _____ Start Date _____ Department _____ Schedule _____ Code of Conduct _____

AGREEMENT

In being considered for a volunteer position at Southern New Hampshire Medical Center, I agree that the Volunteer Services and any of the references provided may exchange information regarding my qualifications without incurring any liability.

If accepted as a volunteer at SNHMC, I agree that I am making a commitment to serve and agree that I will :

Know and support the missions of the Hospital

Be aware of and concerned about how my actions affect patients and their families, visitors, employees, medical staff and fellow volunteers

Call the department of Volunteer Director if unable to be here on my scheduled day

Demonstrate behaviors while interacting with others which include:

1. serve/help the patient, families, visitors and co-workers
2. respect each individual's dignity and privacy
3. focus on meeting customer needs by: following through promptly when responding to requests, collaborating with Volunteer Services or appropriate department to solve problems.

I shall hold as absolutely confidential all information that I may obtain directly or indirectly concerning patients, doctors, or personnel and I will not seek to obtain information from a patient.

I will return my badge and smock when I stop volunteering.

Signature_____

Date_____