VOLUNTEEN APPLICATION

NAME: _____ DATE:_____

ADDRESS_____CITY_____ZIP_____

PHONE:_____EMAIL ADDRESS:_____

CELL PHONE:_____D.O.B._____SCHOOL_____

PRESENT GRADE_____ YEAR OF GRADUATION_____

PARENTS:_____WORK PHONE:_____

_____

REFERENCES: 1._____

2._____

SCHOOL ACTIVITES:_____

_____

Number of people in your household_____

REASONS FOR VOLUNTEERING:_____

_____

TIMES AVAILABLE TO VOLUNTEER_____

AREAS YOU ARE INTERESTED IN VOLUNTEERING_____

VOLUNTEENS MUST BE 14 AND HAVE PARENT'S WRITTEN CONSENT TO VOLUNTEER.

I GIVE PERMISSION FOR _____
TO BECOME A SOUTHERN NEW HAMPSHIRE MEDICAL CENTER VOLUNTEER.

SIGNATURE_____
(PARENT OR GUARDIAN)

To be filled out by Volunteer Director
Reference_____ OIG_____ Criminal Background_____Orientation_____ TB_____

Reference_____ Start Date_____ Department_____Schedule_____

TUBERCULOSIS CONTROL PROGRAM

I _____
(PARENT/GUARDIAN)

AUTHORIZE SOUTHERN NEW HAMPSHIRE MEDICAL CENTER TO ADMINSTER A TUBERCULOSIS TEST ANNUALLY ON:

_____
(STUDENT'S FULL NAME)

AND AGREE NOT TO HOLD THE SOUTHERN NH MEDICAL CENTER RESPONSIBLE FOR ANY AFTER EFFECTS DIRECTLY OR INDIRECTLY CAUSED BY THIS INJECTION.

_____
(PARENT/GUARDIAN)

_____
DATE

EMPLOYEE HEALTH
19 Tyler St. Suite 305
577-2019

HOURS: 8:30 – 4:30 MONDAY - FRIDAY

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_____

Southern New Hampshire Medical Center

VOLUNTEER SERVICES APPLICATION FORM

DATE _____

NAME:_____ HOME TEL:_____ CELL#_____

EMAIL ADDRESS:_____ DATE OF BIRTH_____

ADDRESS:_____ CITY_____ ST_____ ZIP_____

WORK EXPERIENCE:_____

_____

EDUCATION & TRAINING_____

PREVIOUS VOLUNTEER EXPERIENCE:_____

_____

SKILLS & HOBBIES_____

LANGUAGES SPOKEN_____

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: 1._____ PHONE_____

2._____ PHONE_____

WHY DO YOU WANT TO VOLUNTEER?_____

SPECIFY VOLUNTEER SERVICE AREAS OF INTEREST:_____

_____

DAYS AND HOURS AVAILABLE TO VOLUNTEER:_____

Number in household:_____

PLEASE SIGN BACK OF THE FORM

To be filled out by Volunteer Director
Reference_____ OIG_____ Criminal Background_____Orientation_____ TB_____
Reference_____ Start Date_____ Department_____Schedule_____