



Volunteer Application (Adult)

Name _____ Date of birth _____

Mailing Address _____

City, State, and Zip Code _____ email address: _____

Home Phone# _____ Work/Cell Phone# _____

Reference: (do not use family or household member)

Name _____ Phone# _____

Address _____

Education and Employment:

Name of school: _____ Last grade completed: _____

Are you presently employed? _____

Present (or Past) Employer and position held: _____

Health:

Have you had any recent illnesses? _____

Do you have any physical limitations we should be aware of? _____

If yes, please explain _____

Physician _____ Phone # _____

In case of emergency, please call _____ Phone# _____

Skills: (check all that apply):

Typing ___ Photocopying ___ Filing ___ Computer: Excel ___ Word processing ___ Data entry ___

Telephone: Receptionist ___ Survey ___ Customer Service ___ Other _____

Past Volunteer experiences _____

Do you wish patient contact? _____

Job preference _____

Days and times available _____

How did you hear about our Volunteer Program? _____

Have you ever been convicted of, or plead guilty to, a crime within or outside of the State of Connecticut?*

Yes No If yes, please list state(s) and reason(s): _____

I authorize Windham Hospital to solicit all relevant information about this application, including a criminal background check. This authorization for release of information includes but is not limited to factual information and and/or matters of opinion relating to my character, ability, reputation and past conduct.

I authorize and request all persons, schools, prior employers, companies, corporations, credit bureaus and law enforcement agencies to release such information to Windham Hospital, without restriction or qualification. I voluntarily waive all recourse and release them from liability for complying with this authorization.

I affirm that the information I provided on this application, any attached resume or supporting documentation, is complete and accurate. I understand that omission of facts or misrepresentations of information on this application are cause for dismissal from my volunteer assignment if discovered after I start volunteering at the hospital.

I WILL UPHOLD THE TRADITIONS AND STANDARDS OF WINDHAM HOSPITAL. I WILL BE EXTREMELY CAREFUL TO MAINTAIN CONFIDENTIALITY. I WILL ENDEAVOR TO DO MY BEST, BE DEPENDABLE, AND GIVE VOLUNTEER SERVICE OF THE HIGHEST QUALITY.

Signature _____ Date _____

*You are not required to disclose any arrest, criminal charge or conviction pertaining to a finding of delinquency or an adjudication as a youthful offender that has been erased, dismissed or nulled, or for which you were found not guilty or for which you received an absolute pardon. If criminal records have been erased, you are deemed never to have been arrested.

Do not write below this line _____

Interviewer _____ Date _____

Placement _____ Days and time _____

Duties _____

Health Screening Form (Volunteers)

Name: _____ DOB: _____

Address: _____ Telephone Number: _____

Physician's Name: _____ Telephone Number: _____

Emergency Contact Name: _____ Telephone Number: _____

List any chronic health problems or immune disorders: _____

Describe any chronic skin conditions or open wounds: _____

List any allergies: _____

Have you ever had any exposure to active tuberculosis? Yes No

Have you ever had a positive reaction to any of the following tests:

Tine: _____ Intradermal PPD _____

If past positive Tuberculin skin test (PPD) – need to submit copy of negative chest x-ray

Have you ever received the BCG vaccine (a vaccination to prevent Tuberculosis)? Yes No

Are you presently taking any oral steroid (cortisone) medications? Yes No

Date of Tuberculin skin test (PPD): _____ Results: _____

Please list immunizations for the following diseases or attach a copy of immunization records (most recent dates):

Measles, Mumps, Rubella (MMR) 1. _____ 2. _____

Tetanus: _____

Have you ever had chicken pox? Yes No

Have you had the chicken pox vaccine (varicella vaccine)? Yes _____ (date) No

Hepatitis B: 1. _____ 2. _____ 3. _____

I certify that the above health history statements are true and accurate.

Signature _____ Date: _____ (Parent/Guardian's signature for volunteers under 18 years of age)

OFFICE USE ONLY – DO NOT WRITE BELOW THIS LINE

Health history reviewed by: _____ Date: _____
Employee Health Nurse

Any restrictions? Yes No If yes, list restrictions: _____

Follow-up action as indicated: _____

Health Record to: Volunteer Office Student Ed Coordinator Other