



# Volunteer Services Application

The following information will help us to become better acquainted. We are especially interested in your qualifications and interests as a prospective Volunteer.

Please complete and return application to: **Volunteer Services Director, Davis Regional Medical Center, PO Box 1823, Statesville, NC 28687. Telephone: 704-838-7106 Fax: 704-838-7111**

Personal Information:			
First Name	Middle Initial	Last Name	Date
Street Address	City	State	Zip Code
Home Phone	Cell Phone	Email	
Foreign Languages:			
Emergency Contact Information:			
Name		Relationship	
Address		Telephone	
Education (circle appropriate level):			
Elementary & High School 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12	GED	College 13, 14, 15, 16	Graduate School Masters    Doctorate
Employment History			
From: Month / Year	To: Month / Year	Company Name, Complete Address, Telephone, & Supervisor Name	
From: Month / Year	To: Month / Year	Company Name, Complete Address, Telephone, & Supervisor Name	
From: Month / Year	To: Month / Year	Company Name, Complete Address, Telephone, & Supervisor Name	
Volunteer History:			
From: Month / Year	To: Month / Year	Organization or Company Name, Address, Telephone, Contact Name	
From: Month / Year	To: Month / Year	Organization or Company Name, Address, Telephone, Contact Name	
From: Month / Year	To: Month / Year	Organization or Company Name, Address, Telephone, Contact Name	

**Circle the Volunteer Areas(s) and the Day/Time You Prefer:**

<b>Information Desk</b> 9-1 pm, 1-5 pm, 5-8:30 pm, M, T, W, T, F, S, Sun	<b>Outpatient Waiting</b> 9-1 pm, 1-5 pm, 5-8:30 pm, M, T, W, T, F, S, Sun	<b>Gift Shop</b> 9:30 – 1 pm 1-4:30 pm 4:30 – 8:30 pm M, T, W, T, F, S, Sun	<b>Food Services</b> <i>Varied Daytime Hours</i>	<b>ER</b> <i>Varied Daytime &amp; Evening Hours</i>	<b>Other Areas</b> <b>Patient Care;</b> <b>Clerical,</b> <b>Engineering</b>
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**If the hours or departments you have chosen above are not available, are you interested in another area? \_\_\_ yes \_\_\_ no**

**Are you willing to commit to one year of service to the volunteer organization? \_\_\_ yes \_\_\_ no**

**Please List Any Societies, Clubs, or Organizations You are a Member:**


What interests, skills, or hobbies would make you an excellent volunteer for the hospital?

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**Professional References:  
(No Relatives or Personal Friends – may be Past Employers, Work Associates, Clergy, etc.)**

<b>Name &amp; Relationship to You</b>	<b>Complete Address</b>	<b>Telephone Number</b>
		Day: Evening:
		Day: Evening:
		Day: Evening:

*(Because of the extensive amount of training, orientation, and background research involved in becoming a volunteer, volunteers must be willing to commit at least one year of service and be able to work a minimum of 4 hours per week. By completing this application, you are indicating you understand and are agreeable.)*

Applicant's Signature:	Date:
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**• FOR APPLICANTS UNDER 18 YEARS OF AGE:**

I hereby agree to the above conditions, and give my child/ward permission to be a volunteer at Davis Regional Medical Center.

Signature:	Date:
Please print name & your relationship to the applicant:	

## Health Screening Record

Personal Information			
First Name	Middle Initial	Last Name	Date
Street Address	City	State	Zip Code
Home Phone	Business Phone	Email Address	
Primary Physician			
Name	Address		
Communicable Disease History			
Place check any of the following illnesses you have had in the past.			
	Mumps	Measles (“Big Red Measles”)	
	Chicken Pox	Rubella (German Measles)	
Immunizations (complete with dates if born 1957 or after)			
Polio	Mumps	PPD Date:	
DPT	Rubella	Results:	
Measles	Tetanus	Previous Results:	
General Health Information			
Do you take medicine that may cause you to be drowsy or impair your ability to perform the duties of a volunteer? Yes ___ No ___ If yes, indicate what medications:			
Do you have any medical conditions that we need to be aware of in the event you become ill while on duty?			
Do you have other medical conditions not mentioned above, or any restrictions that would limit your volunteer activities? Please comment below:			
Date:	Signature:		

**Davis Regional Medical Center**  
**Sunshine Volunteers**  
*Release Authorization*

In consideration of my application, I authorize *Davis Regional Medical Center* by and through QPI to verify all data given by me on application, related papers or oral interviews. I understand a thorough investigation may be conducted which may include but not be limited to criminal history, motor vehicle driving record, education verification, employment history, credit report and personal history. I hereby authorize employers, agencies, personal references and other persons with whom I am acquainted to answer all questions and release all information concerning my employment record, character, reputation, ability, education, military service, credit history and other applicable reports. Furthermore, I release all agencies, bureaus, employers, information service organizations, and individuals or companies named above from all liabilities or damages that might result from information provided in good faith. I state that the information provided by me on my application is accurate and I agree that if any information therein is found to be false at any time, my application may be discarded or my volunteer status terminated. I understand that the information requested below regarding sex and date-of-birth are for the sole purpose of gathering the above information accurately and will not be used to discriminate against me in violation of the law. \* A facsimile (FAX) or photocopy of this authorization shall be as valid as the original.

\*QPI fully complies with the Fair Credit Reporting Act and the ADA.

(Print) Last name	First	Middle	Social Security Number	
Maiden and/or other Name Used			Driver's License Number / State Issued	
Current Address (Street)			Date of Birth	Sex
City, State, Zip Code and County			Applicant's Signature	

**List Previous Addresses, other than that above, for the past seven years:**

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(Street Address)	(City)	(State)	(Zip Code)
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