



# 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 be sure to complete front and back.**

**Please complete and return application to: Volunteer Services, Davis Regional Medical Center  
PO Box 1823, Statesville, NC 28687 Telephone: 704-838-7255 Fax: 704-838-7111**

Personal Information:				
First Name	Middle Initial	Last Name		Date
Street Address	City		State	Zip Code
Home Phone	Cell Phone	Email		
Driver's License # / State Issued	Social Security #	Date of Birth		
Emergency Contact Information:				
Name			Relationship	
Address			Telephone	
Education (circle appropriate level):				
High School Name (GED) & Location 9, 10, 11, 12	College Name & Location 1, 2, 3, 4		Graduate School Name & Location Master's    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		
Volunteer History: <i>Please List Any Societies, Clubs, or Organizations You are a Member</i>				
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 Area(s) & Day/Time You Prefer:				
<b>Information Desk</b> 9-1, 1-5, 5-8:30 pm M, T, W, T, F, S, Sun	<b>Outpatient Waiting</b> 6-8 am, 9-1 pm 1-5 pm M, T, W, T, F	<b>Gift Shop</b> 9:30-1 pm, 1-4:30 pm M, T, W, T, F	<b>ER</b> Varied Day & Evening Hours	<b>Other Areas: Patient Care, Clerical, Support Services</b>
<b>If the hours or area you chose is not available, are you interested in another area?    <input type="checkbox"/> yes    <input type="checkbox"/> no</b> <b>Are you willing to commit to one year of service to the volunteer organization?    <input type="checkbox"/> yes    <input type="checkbox"/> no</b>				

<b>Professional References:</b> <i>(No Relatives or Personal Friends – may be Past Employers, Work Associates, Clergy, etc.)</i>		
<b>Name &amp; Relationship to You</b>	<b>Complete Address</b>	<b>Telephone Number</b>
		Day:  Evening:
		Day:  Evening:
		Day:  Evening:

<b>General Health Information:</b>
Do you take medicine or have any medical conditions that would limit your volunteer activities? If yes, please describe.
Do you have any medical conditions that we need to be aware of in the event you become ill while on duty?

I understand and I authorize the company and any persons and entities associated with Davis Regional to conduct a background investigation related to my application which will include the obtaining of Investigative Consumer Reports and Consumer Reports. Such investigations may also include obtaining information about me such as my employment(s), personal history, character, general reputation, criminal, licensure/certification, credit and driving histories.

In connection with this investigation I authorize, without reservation, Davis Regional to obtain information from other persons and entities (such as other employers, companies, schools, government entities and credit agencies) for information about me, and for those persons or entities to release it without reservation.

This authorization, in original, electronic or copy form, shall be valid for this and any future investigations(s) conducted by Davis Regional including, if I am employed, for promotion, reassignment or retention of employment.

I am aware that if I am denied employment based on a report by a consumer-reporting agency, Davis Regional will furnish the name and address of such agency upon my written request.

*(Because of the amount of training, orientation, and background research involved in becoming a volunteer, volunteers must be willing to commit to an in-house TB test, drug test, and fulfill at least one year of service working a minimum of four hours per week. By completing this application, I understand and I will commit.)*

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

*I hereby agree to the above conditions, and I give my child/ward permission to be a volunteer at Davis Regional Medical Center. I also agree to allow my child/ward to undergo required health tests (i.e. TB & Drug).*

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