

Name: _____
Last First Middle Initial

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell Phone: _____ Carrier: (ex. Verizon, AT&T) _____

Birthdate: _____ T-Shirt Size: _____

Email: _____

School attending: _____

Grade currently completed: _____ GPA: _____

Are you interested in a health career? _____ If yes, which? _____

Other reason(s) why you are interested in being a volunteer: _____

Will your schedule permit you to complete the 10 week program, other than time away for vacation? Yes No

If no, please explain. _____

Have you participated in other community volunteer organizations? Yes No

If yes, which and list duties: _____

How did you become interested in our program? _____

SPECIAL SKILLS/INTERESTS

In the order of preference (1-3), please select areas of interest.

- | | |
|--|---|
| () Community Relations Decatur Campus | () Rehab Access Decatur Campus |
| () Emergency Room Decatur Campus | () Labor and Delivery Decatur Campus |
| () Food Services Decatur Campus | () Inpatient Nursing Parkway Campus |
| () PACU Decatur Campus | () Emergency Department Parkway Campus |
| () Respiratory Therapy Decatur Campus | () Admissions Parkway Campus |
| () Admissions Decatur Campus | () Respiratory Therapy Parkway Campus |
| () Pre-Admission Testing Decatur Campus | |

Volunteer hours are between 8:00 am and 2:00 pm.

Please circle days you are available: Monday Tuesday Wednesday Thursday Friday



CONFIDENTIALITY STATEMENT

I understand that as a Decatur Morgan Volunteer, I will not be paid for services. I agree, in the performance of my duties, I must hold in strictest confidence any observations I may make or hear regarding patients, patients' families or hospital staff.

I understand that intentional or involuntary violation of confidentiality may result in disciplinary action including termination.

Date: _____ Applicant: _____

FOR PARENT TO COMPLETE

Do you object to your child having a TB skin test? Yes No

Parental Consent:

I hereby agree to allow my child to serve as a volunteer at Decatur Morgan Hospital. I fully understand in the course of duties my child will be permitted to enter patient areas and/or patient rooms. I understand that as a volunteer my child will not receive pay for services.

Date: _____ Parent or Legal Guardian: _____

EMERGENCY CONTACT

Name: _____

Address: _____

Contact Number: _____ Cell Home Work

Family Doctor: _____ Phone: _____

DO NOT WRITE BELOW THIS DOTTED LINE

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Date Interviewed: _____ Interviewed By: _____

Comments: _____

