JENNIE EDMUNDSON HOSPITAL
An Affiliate of Methodist Health System

**Jennie Edmundson Hospital**
**Volunteer Services**

**VOLUNTEER APPLICATION**

❒ Adult ❒ Teen
❒ Special Events
VolWorks #:_____
Date _____

Name: _____ Birth Month/Day/Year: ____-___-___
(Last) (First) (Middle)

Address: _____ City/State/Zip: _____

Home Phone: (___) _____ - _____ Cell Phone: (___) _____ - _____

E Mail Address: _____

Year-Round Resident? _____ Yes _____ No If no, list available months_____

Emergency Contact: _____ Relationship: _____

Home Phone: (___) _____ - _____ Cell Phone: (___) _____ - _____

Work Phone: (___) _____ - _____

Are you currently a student? ❒ Yes ❒ No **If yes,** where? _____

Previous Volunteer or Paid Employment Experience: _____

_____

Hobbies, Skills, or Special Interests: _____

_____

Have you ever volunteered at Jennie Edmundson Hospital in the past? ❒ Yes ❒ No **If yes,** when and in what capacity? _____

How were you referred to Jennie Edmundson Hospital? _____

Have you ever been convicted of a misdemeanor or felony? ❒ Yes ❒ No **If yes**, please explain: _____

_____

Do you need verification of your Jennie Edmundson Volunteer hours for a requirement? ❒ Yes ❒ No

**If yes,** where, and why? _____

Contact person: _____

Are you fluent in any language(s) other than English? ❒ Yes ❒ No **If yes,** which one(s)? _____

**Indicate Preferred Days & Hours**

| | *M* | *T* | *W* | *TH* | *F* | *SAT* | *SUN* |
|---|---|---|---|---|---|---|---|
| *Morn* | | | | | | | |
| *Aft* | | | | | | | |
| *Eve* | | | | | | | |

**Volunteer Areas of Interest:** *(✓ all that apply)*

| | |
|---|---|
| ❒ *Lobby / Information Desks* | ❒ *Office Work* |
| ❒ *Gift Shop / Pharmacy Annex* | ❒ *Fundraising / Special Events* |
| ❒ *Waiting Room Desks* | ❒ *Road to Recovery Drivers* |
| ❒ *Emergency Department* | ❒ *Other: Mentoring / Sewing* |

**VOLUNTEER STATEMENT**: I wish to donate my services to Jennie Edmundson Memorial Hospital and understand there is no payment for services rendered as a volunteer at Jennie Edmundson Hospital. I understand that the Hospital and Volunteer Staff may take photographs of me for publications or other uses. I agree to abide by the rules, regulations and policies of the Hospital department in which I serve and Volunteer Services Department. I further understand confidentiality must be maintained concerning patient and family information. I understand that if I do not abide by the Hospital Department and Volunteer Services Department rules, regulations and policies, that I will be terminated from the volunteer program.

Volunteer Signature: _____ Date: _____