

ADULT VOLUNTEER APPLICATION

Addison Gilbert Hospital, Beverly Hospital and Lahey Outpatient Center, Danvers

Volunteer Services 85 Herrick St., Beverly, MA 01915 (978)922-3000 x2307

This application is for ADULT VOLUNTEERS.

Volunteer applicants under age 18 must fill out a student application.

PERSONAL DATA

Home Phone () Work Phone () Email address Cell Phone () Emergency Contact () Phone number I want to volunteer at: Beverly Hospital Lahey Outpatient Center, Danvers Addison Gilbert Hospital (Gloucester) Cummings Center (Beverly) WORK / VOLUNTEER EXPERIENCE Employment: Please include place of employment, position, and dates Have you volunteered for or been employed by this organization before? YES NO If YES, please give dates Present and Previous Volunteer Experience. Please describe How did you hear about volunteering for this hospital? Church bulletin Internet Brochure Newspaper Other If other, where? Are you a current college student? YES NO	Name	Birth Date			
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If other, where?	ž	_	-		
If YES,	If other, where?				Other
	Are you a current colle If YES,	ege student?	YES	NO	_
		e/University		Graduation	n Date

MOTIVATION FOR VOLUNTEERING

Reasons for volunteer	ing					
Is this required? YES court other			•			
What experiences have attitudes?	•	-			y affected	your
INTERESTS / SKILLS	S / HOBB	IES				
Please indicate your ir	nterests, s	kills, hobl	oies			
COMMITMENT						
To ensure that you derive the maximum benefits from your volunteer service, the Volunteer Services Department requires that all volunteers give a minimum commitment of 50 HOURS per calendar year, or as determined during the placement process.						
TIME AVAILABLE: (PI			1			
SUN.	MON.	TUES.	WED.	THUR.	FRI.	SAT
MORNING			-			
<u>AFTERNOON</u>			-			
EVENING Volume on and	<u> </u>	doto				<u> </u>
Volunteer ass	ignments	are deter	rminea das	ea on no:	spitai nee	eas.
Please indicate your aConnecting YoungDepartment Greete	g Moms, Ca er (Surgery	hild Careg	•	<i>U</i> ,	anvers & I	Radiology: BH)
Gift Shop (AGH &	,					
Emergency Dept.	,	, .		, ,	•	,
Information Desk	•	,		•	-	•
Office Support (Au				_		Danvers
Patient Services (7				• ,		
Spectrum Center,		•	gs Ctr. and	North An	doverj	
Senior Adult Unit, Other:	Activities	(AGH)				
When are you availabl	e to hegin	— volunteer	ring?			

PERSONAL REFERENCES

Please complete all fields possible. PLEASE DO NO?	below: reference form	s will be ema	<u>iiled</u> whenev	er
1 Name				
1. Name	last			
Address				
Addressstreet	city	state	zip	
Email Address*(Please inclu	de):			
Phone ()	Relationship to A	applicant		
2. Namefirst		last		
Addressstreet		state	zip	
Email Address*(Please inclu				
Phone ()	Relationship to A	Applicant		
STATEMENT OF UNDERSTA	ANDING			
-I affirm that the information	provided on this applicat	ion is true and	complete.	
-I understand if I am accepte with hospital policies and pro	•	_		ce
-I understand the Volunteer service as a volunteer.	Services Department rese	rves the right to	o terminate my	7
-I understand I will not be co services.	mpensated monetarily by	the hospital fo	r my volunteer	?
-I authorize the hospital to movel volunteering.	nake any inquiries to deter	rmine my suita	bility for	
-I understand Criminal Offen volunteer applicants over the		-		.)
Your Signature		D	ate	

For Office Use Only:	
Information Meeting:	Assignment:
References Sent:	Day:
CORI Sent:	Time:
References Received:	Start Date:
Orientation:	TB read:
Kronos#:	Meal Voucher#:
For Office Use Only:	

COMMENTS: