Date received: _____
Date interviewed: _____
FOR OFFICE USE ONLY

Volunteer Application

Name (First, Middle, Last):	4-Digit PIN:	Birthdate:
Home Address (Street, Apartment Number):	Adult ☐ College ☐ High School ☐	
City, State, Zip:	Telephone No. Home/Work/Cell:	
Emergency Contact: Relationship and Phone Number: 1. 2.	Social Security # : Email:	

Physician: _____ City: _____

Work or Volunteer Experience
1.
2.
3.
4.
5.

References (Not Relatives)		
Name	Address, City, State, Zip	Telephone Number

Volunteer Areas of Interest:

_____

_____

_____

Do you have a record of founded child or dependent adult abuse or have you ever been convicted of a crime in this state or any other? □ Yes □ No

If yes, please specify: _____

_____

Allen Hospital will consider all qualified individuals interested in contributing volunteer service without regard to race, religion, disability, color, age, sex or national origin.

(over)

Please Read

By signing below, I certify that the answers and information set out on the previous page are accurate and complete, to the best of my knowledge. I acknowledge that if any answer or information is not accurate, or complete, I may not be asked to provide volunteer services.

1. I authorize Allen Hospital to investigate all statements contained in this application for volunteer service, as well as my character and qualifications. I release Allen Hospital from all liability for acts performed in good faith and without malice in connection with the investigation of my background and evaluation of my application.

2. I authorize my past and present employers, volunteer organizations and others with information regarding my work, volunteering or my character to provide Allen Hospital with all information requested and to cooperate fully with the inquiry of my character qualifications. I also release those employers, references, and others from all liability for providing information in good faith and without malice.

3. I understand and agree that the relationship between myself and Allen Hospital may be terminated at any time by either party.

4. I understand that my acceptance to volunteer in patient contact areas depends on Allen Hospital ensuring that I have no health problems which would prevent me from volunteering effectively and with complete safety for myself and Allen Hospital patients, employees and visitors. Accordingly, I agree that if my health changes, I will submit a new medical clearance form from my physician and that my acceptance to volunteer will depend upon approval of Allen Hospital.

5. I understand that as a volunteer, I must conform to all Allen Hospital rules and regulations including those in the orientation manual. I also understand that I will be required to obtain and wear appropriate volunteer uniform. This uniform includes a name tag and a shirt, jacket or vest.

6. Please note that your volunteer commitment at Allen Hospital includes commitment to confidentiality. Names, diagnoses, and other patient/client information must not be shared. Discussing a patient/client or the patient's/client's condition is strictly prohibited and could create legal liability for Allen Hospital and you. This commitment to confidentiality extends to all communications taking place not only in the hospital but also outside the hospital.

7. I hereby give permission to Allen Hospital to conduct an Iowa criminal history and dependent/child abuse registry check with the Division of Criminal Investigation.

Signature_____ Date_____

Please return completed form to Volunteer Services, Allen Hospital.

Submit