JEFFERSON
REGIONAL MEDICAL CENTER
Medical excellence closer to home

VOLUNTEER APPLICATION

DATE OF APPLICATION: _____

PERSONAL

NAME (LAST) (FIRST) (MIDDLE) PHONE

CELL

ADDRESS CITY STATE ZIP

EMAIL ADDRESS BIRTH DATE (YEAR OPTIONAL) AGE

VOLUNTEER TYPE: ☐ ADULT ☐ MIDDLE/HIGH SCHOOL STUDENT ☐ COLLEGE STUDENT ☐ INTERN

EXPERIENCE

EDUCATION

WORK EXPERIENCE / CAREER PLANS

VOLUNTEER EXPERIENCE

SPECIAL TRAINING (HOBBIES OR INTERESTS)

VOLUNTEER INTEREST

PROGRAM INTEREST: WE SHALL ASSIGN YOU ACCORDING TO AVAILABILITY, INTERESTS, SKILLS AND OUR NEEDS. CHECK ASSIGNMENT(S) WHICH APPEAL TO YOU.

☐ GIFT SHOP
☐ CHART ASSEMBLY
☐ SPIRITUAL CARE
☐ FRONT DESK
☐ ESCORT SERVICE
☐ PHYSICAL THERAPY
☐ PATIENT REPRESENTATIVE
☐ NURSING UNIT ASSISTANT
☐ DEPARTMENT HOST/HOSTESS

DAY(S) AND TIME(S) YOU WOULD LIKE TO VOLUNTEER:

WOULD YOU LIKE TO BE CONSIDERED FOR SPECIAL PROJECTS? ☐ YES ☐ NO

MEDICAL INFORMATION

PERSON TO CONTACT IN CASE OF EMERGENCY PHONE

AT THE PRESENT TIME, IS THERE ANY PHYSICAL CONDITION WHICH COULD LIMIT PARTICIPATION IN THE VOLUNTEER PROGRAM? IF YES, EXPLAIN:

PHYSICIAN'S NAME PHONE

BACKGROUND

WHY ARE YOU INTERESTED IN VOLUNTEERING?

HAVE YOU EVER VOLUNTEERED AT JEFFERSON REGIONAL MEDICAL CENTER (FORMERLY ST. JOSEPH'S HOMESTEAD HOSPITAL AND SHHS)? ☐ YES ☐ NO IF YES, DATES:

HAVE YOU EVER BEEN EMPLOYED BY JEFFERSON REGIONAL MEDICAL CENTER (FORMERLY ST. JOSEPH'S HOMESTEAD HOSPITAL AND SHHS)? ☐ YES ☐ NO IF YES, POSITION:

HOW DID YOU FIND OUT ABOUT OUR PROGRAM?
REFERRED BY:

HAVE YOU EVER BEEN CONVICTED OF, PLEADED GUILTY TO, OR ENTERED A PLEA OF NOLO CONTENDERE (NO CONTEST) TO ANY VIOLATION OTHER THAN A SUMMARY OFFENSE ☐ YES ☐ NO

HAVE YOU EVER ACCEPTED ACCELERATED REHABILITATIVE DISPOSITION (ARD), PROBATION WITHOUT VERDICT (PWV) OR A SIMILAR COURT MONITORED PROGRAM OTHER THAN A SUMMARY OFFENSE? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN:

REFERENCE

REFERENCE NAME	RELATIONSHIP		PHONE
ADDRESS	CITY	STATE	ZIP
REFERENCE NAME	RELATIONSHIP		PHONE
ADDRESS	CITY	STATE	ZIP

PARENT OR GUARDIAN CONSENT

IF THE APPLICANT IS UNDER THE AGE OF 18, A PARENT OR GUARDIAN MUST SIGN BELOW GIVING PERMISSION FOR THE APPLICANT TO VOLUNTEER.

PARENT/GUARDIAN SIGNATURE DATE

VOLUNTEERS ARE REQUIRED TO CONFORM TO THE MEDICAL CENTER'S CODE OF ETHICS AND SERVICE EXCELLENCE COMMITMENT. TO BE ACCEPTED INTO THE VOLUNTEER PROGRAM, WE REQUIRE A MINIMUM COMMITMENT OF AT LEAST 50 HOURS PER YEAR.

APPLICANT'S SIGNATURE

I CERTIFY THAT ALL STATEMENTS MADE BY ME ON THIS APPLICATION ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT ANY FALSE STATEMENT, MISREPRESENTATION OR OMISSION MAY CAUSE MY DISMISSAL FROM VOLUNTEER SERVICE.

SIGNATURE OF APPLICANT DATE

OFFICE NOTES

JEFFERSON REGIONAL MEDICAL CENTER IS AN EQUAL OPPORTUNITY EMPLOYER. NO QUESTIONS ON THIS APPLICATION ARE ASKED FOR THE PURPOSE OF LIMITING OR EXCLUDING ANY APPLICANT'S CONSIDERATION FOR VOLUNTEER SERVICE BECAUSE OF RACE, COLOR, RELIGION, SEX, AGE, NATIONAL ORIGIN, SEXUAL ORIENTATION, DISABILITY, OR VETERAN STATUS.

RETURN APPLICATION TO:
VOLUNTEER SERVICES
JEFFERSON REGIONAL MEDICAL CENTER
P.O. BOX 18119
PITTSBURGH, PA 15236-0119
OR
FAX: 412-469-7528