



Our Mission
is to provide Christ-like healing
to the community through education,
treatment, and health services.

Volunteer Application

Name: Birthdate:

Address: City: State: Zip:

Home Phone: Cell Phone: Business Phone:

Email address:

Occupation:

Business Address: City: State: Zip:

Social Security Number: Marital Status:

Spouse's Name: Number of Children: Ages:

REFERENCES (Please list names and addresses):

- 1. Telephone:
2. Telephone:
3. Telephone:

Do you know anyone who volunteers at St. Bernards Medical Center? Yes No If so, please list their names below:

Have you ever volunteered at St. Bernards Medical Center? Yes No If so, please indicate where below:

Are you a veteran? Yes No

Have you belonged to any other volunteer organizations? Yes No If so, please list the name of the organizations:

MEMBER PROFILE:

Previous business experience (list by title please):

What skills have you developed?

- Writing Secretarial Art Musical Nursing
Event Planning Photography Advertising Bookkeeping Public Speaking
Fundraising Planning Calligraphy Crafts Public Relations
Computer Use Other

Did any particular event lead to your decision to volunteer at St. Bernards Medical Center?

What type of assignment are you seeking?

How many hours per week do you feel you can commit to volunteering?

Please list any available day, night, time and frequency you would be able to volunteer:

Best Time to call: Are you willing to be assigned to short-term projects? Yes No

In the event of a community-wide disaster (i.e., plane crash, tornado, major fire) which resulted in the immediate admission of a large number of emergency patients, would you be willing to work extra hours wherever needed? Yes No

Other Commitments?:

Have you ever been convicted of a crime other than a minor traffic offense? If yes, please discuss with us in confidence

MEDICAL REPORT

The following information is for the use of the Volunteer office to assist in safeguarding your health.

What is your general state of health? Excellent Good Fair Poor

Have you ever been hospitalized for treatment of alcoholism or mental illness? Yes No If yes, explain:

Do you have any back trouble? Yes No If yes, explain:

Are you unable to stand or walk for long periods of time or are you restricted in any other way? Yes No If yes, explain:

Physician to be called in case of accident or illness: Name: Telephone:

Persons to be notified in case of emergency: Name: Telephone:

Name: Telephone:

