Volunteer Application

Online applications now available!

CARROLL HOSPITAL
A LifeBridge Health Center

Name: _____

Home Address: _____

_____ **Home Phone:** _____

Email: _____ **Cell Phone:** _____

Name of current or past employer: _____

Address: _____ **Phone:** _____

Previous Volunteer Experience: _____

Address: _____ **Dates:** _____

Community Affiliations: (Churches, clubs, other organizations)

_____

Education or Special Training: _____

Are you covered by a Health Insurance Plan? Yes _____ No _____

Have you been convicted of a crime? Yes _____ No _____

If yes, please explain: _____

Personal References: (please provide two personal references with full addresses not related to you)

Name: _____ **Phone:** _____

Address: _____ **Email:** _____

_____

Name: _____ **Phone:** _____

Address: _____ **Email:** _____

_____

For admin purposes: Reference letters mailed: _____ Date: _____

Please see other side

Please circle days and times you will be available to volunteer:

Monday Tuesday Wednesday Thursday Friday Saturday Sunday

8a.m.-12 noon 12noon-4p.m. 4p.m.-8p.m. Other: _____

Department Interest (circle all that apply)

Emergency Department Information Desk Clerical Volunteer Room Cancer Center Retail

Patient Relation Surgical Services Other: _____

Person to be contacted in case of an emergency:

Name: _____ Home phone: _____

Relationship: _____ Cell phone: _____

As a volunteer at Carroll Hospital, I agree to:

- **Be punctual and conscientious in the performance of assigned duties**
- **Commit to at least 60 hours of service annually**
- **Conduct myself with dignity, courtesy and respect for others by adhering to the organization's core values of Service, Performance, Innovation, Respect & Teamwork.**
- **Comply with the standards, policies and procedures of the Volunteer Services Department and Carroll Hospital**
- **Discuss concerns and complaints with the Volunteer Manager or my immediate Supervisor**
- **Attend required Volunteer education programs**
- **Adhere to the medical requirements of Carroll Hospital**
- **Portray a positive Volunteer presence by complying with the Volunteer Services Department dress code**
- **Wear my Hospital identification badge while on duty**

I certify that the information on this application, to the best of my knowledge, is true and I understand that any misrepresentation or willful omission of fact can be cause for dismissal from the volunteer program. I hereby authorize Carroll Hospital to verify any information on this application.

_____ _____

Applicant's Signature Date

_____

Print name

Return complete application to: Volunteer Services Office
Carroll Hospital
200 Memorial Avenue
Westminster, MD 21157

Thank you again for your interest in volunteering at Carroll Hospital a LifeBridge Health Center.