VOL-05-FRM
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APPLICATION FOR VOLUNTEER SERVICES / THE CMC AUXILIARY

AREA OF INTEREST:
CONWAY MEDICAL CENTER____ HOSPICE HOUSE _____ HOSPICE HOME CARE_____

PATIENT CONTACT _____ NON PATIENT CONTACT _____ CLERICAL _____ SPIRITUAL CARE_____

DATE:_____

NAME:_____

STREET ADDRESS_____

CITY/STATE_____ZIP_____

PREFERRED TELEPHONE # _____

E-MAIL _____

BIRTHDAY: MONTH_____DAY _____ YEAR_____

ARE YOU UNDER THE AGE OF 18? YES_____NO_____

DRIVERS LICENSE# _____ STATE_____

EDUCATION LEVEL _____ MAJOR COURSE OF STUDY:_____

HOW DID YOU LEARN ABOUT OUR PROGRAM:
Friend ____ church ____ media ____ other_____

HOBBIES/INTEREST_____

HAVE YOU HAD EXPERIENCE OPERATING THE FOLLOWING OFFICE EQUIPMENT?
COMPUTERS_____COPY MACHINES_____CASH REGISTERS_____

PAST WORK EXPERIENCE:_____

ARE YOU CURRENTLY ABLE TO PERFORM THE DUTIES REQUIRED OF A VOLUNTEER?
(I.E. Pushing wheelchair, walking, standing etc)_____

WHY ARE YOU INTERESTED IN A VOLUNTEER POSITION OR THE AUXILIARY AT CONWAY MEDICAL CENTER

_____

_____

_____

PREVIOUS VOLUNTEER
EXPERIENCE_____

ARE YOU CURRENTLY EMPLOYED? YES_____ NO_____

I AM ELIGIBLE TO LEGALLY RESIDE IN THE UNITED STATES YES_____ NO_____

DO YOU RESIDE IN THIS AREA PERMANENT _____ PART-TIME _____

WHAT ARE YOUR DAYS/HOURS OF AVAILABILITY TO VOLUNTEER

Sun___ Mon___ Tues___ Wed___ Thurs___ Fri___ Sat___

Morning ___ Afternoon ___ Evenings ___ Nights ___

IN AN EMERGENCY NOTIFY_____PHONE_____

Relationship _____

PLEASE LIST NAMES AND ADDRESS OF TWO PERSONAL REFERENCES
(Please no FAMILY relatives or Church Pastors)

1st.Name:_____PHONE_____

Address:_____
Street

_____
City State Zip

2nd.Name:_____PHONE_____

Address:_____
Street

_____
City State Zip

The organization will recruit adult volunteers without regard to disability, race, color, creed, gender, genetic disposition, religion, national origin, sexual orientation, familial status, veteran status, marital status or any other legally protected status.

The Volunteer Services is a department of Conway Medical Center. The CMC Auxiliary is a non-profit charitable 501 c 3 corporation providing fund raising activities to benefit Conway Medical Center.

I hereby understand and agree:

- The acceptance of this application does not create an expressed or implied contract to volunteer.
- I understand that I will be required to complete an onboarding orientation packet prior to beginning my volunteer duties.
- I understand I must complete a Health Assessment packet with the CMC Employee Health Department.
- I understand that if I am issued a volunteer ID badge, I will wear my ID badge while on duty as a volunteer in accordance with hospital policy and it remains the property of CMC and must be returned upon departure.
- I understand and agree that at no time will any information regarding patient(s) of Conway Hospital entities be revealed to anyone other than those authorized to receive it.
- I understand that the giving of the information concerning patient(s) to those not authorized to receive such information is unlawful and shall be sufficient cause for my immediate dismissal.
- I understand that false statements made as part of this enrollment may be considered sufficient cause for dismissal.
- I understand that all CMC owned, rented and leased properties are nicotine free.
- I understand photos/videos taken while participating as a volunteer or at special functions may be used for promotional reasons.
- I understand my contact information may be shared with CMC Foundation and/or CMC Auxiliary.

I hereby authorize Conway Medical Center to receive any criminal history, motor vehicle information, personal credit history, employment history and educational records and similar types of information from any and all governmental agencies, individuals and/or parties or agencies which may generate or maintain such information.

I hereby release said hospital, companies, schools, or persons from all liability for any damage for issuing this information. In addition, if accepted as a volunteer, I hereby agree to abide by the rules and policies of the healthcare organization and agree to accept no monetary compensation for volunteer services provided.

I hereby agree not to hold Conway Medical Center liable for their transmittal or use of their reliance on any of the information even if my volunteer status is terminated or I am denied the volunteer position.

I certify that all answers given by me to the foregoing questions and statements are true and correct.

SIGNATURE_____DATE_____

ID Verified by _____ DATE_____

VOLUNTEER OFFICE REPRESENTATIVE

CONWAY MEDICAL CENTER – VOLUNTEER SERVICES AND/OR AUXILIARY
300 SINGLETON RIDGE ROAD, CONWAY, SOUTH CAROLINA 29526
TELEPHONE: 843-234-5486 FAX: 843-234-6811