



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

## APPLICATION FOR VOLUNTEER SERVICES AND/OR THE AUXILIARY TRADITIONAL

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

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PREVIOUS VOLUNTEER  
EXPERIENCE \_\_\_\_\_

AREA OF INTEREST: PATIENT CONTACT \_\_\_\_ NON PATIENT CONTACT \_\_\_\_ CLERICAL \_\_\_\_

ARE YOU CURRENTLY EMPLOYED? YES \_\_\_\_\_ NO \_\_\_\_\_

I AM ELIGIBLE TO LEGALLY RESIDE IN THE UNITED STATES YES \_\_\_\_\_ NO \_\_\_\_\_

DO YOU RESIDE IN THIS AREA (please circle), 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 relatives or Church Pastors)**

1st.Name: \_\_\_\_\_ PHONE \_\_\_\_\_

Address: \_\_\_\_\_  
Street

City State Zip

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2nd.Name: \_\_\_\_\_ PHONE \_\_\_\_\_

Address: \_\_\_\_\_  
Street

City State Zip

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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 \_\_\_\_\_ SS# \_\_\_\_\_ DATE \_\_\_\_\_

ID Verified by \_\_\_\_\_ DATE \_\_\_\_\_  
*VOLUNTEER OFFICE REPRESENTATIVE*