

**PLEASE PRINT**

Today's Date: \_\_\_\_\_

**Name:** \_\_\_\_\_**Address:** \_\_\_\_\_  
Street City State Zip**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_**Email:** \_\_\_\_\_  
For Volunteer Services use only.**Emergency Contact:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
Name/RelationshipSpecial training, skills, or interests: \_\_\_\_\_  
\_\_\_\_\_Do you speak a foreign language? ☐ No ☐ Yes; explain: \_\_\_\_\_Community Affiliations: \_\_\_\_\_  
\_\_\_\_\_**Referred by (name):** \_\_\_\_\_ **Phone:** \_\_\_\_\_**Personal Reference (name):** \_\_\_\_\_ **Phone:** \_\_\_\_\_**Address:** \_\_\_\_\_  
Street City State Zip**Area(s) of Volunteering Interest:**

- ☐ Patient Services (Reception/Escort, Respite Care, "Lend an Ear" Volunteer, etc.)
- ☐ Community Outreach (Tele-Care Callers, Blood Drives, Appointment Reminder Calls, etc.)
- ☐ Fundraising (Holiday Tea, Love Light Program, Vendor Sales, etc.)
- ☐ Other (Office Work, Telephoning, Knitting, Sewing, Cardmaking, etc.)
- ☐ Committee (Orientation, Scholarships, etc.)

Days of the Week Available: \_\_\_\_\_

Times of the Day Available: \_\_\_\_\_

Reason for Volunteering: \_\_\_\_\_

How did you hear about our Volunteer Program? \_\_\_\_\_

I understand and agree that at no time will any information regarding patients be revealed to anyone other than those authorized to receive it. I understand that the giving of the information concerning a patient to those not authorized to receive information is unlawful and shall be sufficient cause for my immediate dismissal.

I agree to any necessary health screening required and understand my volunteer assignment is contingent upon successful completion of this screening, completing any necessary immunizations, and attending orientation.

I understand that any false statements made as a part of this application may be considered sufficient cause for dismissal.

I authorize permission for all named references and educational institutions to release personal and professional information to the Volunteer Services office. I also consent to an annual police record search and a Department of Motor Vehicles check. I further release Black River Health, Black River Falls, WI, as well as those supplying said information from any and all liability from these investigations.

I UNDERSTAND THAT IF ACCEPTED AS A VOLUNTEER I WILL ABIDE BY THE GENERAL POLICY CONCERNING CONFIDENTIALITY. My assignment is on a probationary basis for a period of 70 days. I voluntarily offer my services with a clear understanding that there is no monetary compensation. I will observe all mandatory regulations.

\_\_\_\_\_  
**Applicant Signature**

\_\_\_\_\_  
**Date**

**FOR VOLUNTEER SERVICES TO COMPLETE**

Interview Date: \_\_\_\_\_ Date Application Received: \_\_\_\_\_