

Memorial Hospital of Lafayette County
800 Clay Street, Darlington, WI 53530 608.776-4466

Volunteer Application

Name: _____

Address: _____

Telephone Number: _____ Birth Date: _____

Email Address: _____

Present Status: Employed Retired Student Other: _____

Area of Volunteering that interests you: _____

Type of Volunteer time commitment desired:

Weekly: hours available _____ Monthly: days available _____ On-Call

Other: Please describe your desired hours: _____

Volunteer Work

Experience: _____

Why are you interested in Volunteering for Memorial Hospital of Lafayette County:

References:

Please list the name and telephone number of three people who can describe your character, and who are not related to you:

<i>Name:</i>	<i>Telephone:</i>	<i>Years Known:</i>

In Case of Emergency, notify:

Name: _____ Phone: _____

Any Physical Limitations: Yes No If yes, indicate: _____

If accepted as a hospital volunteer of Memorial Hospital of Lafayette County, I agree that:

1. I shall hold as absolutely confidential all information that I may obtain directly or indirectly concerning patients, doctors, personnel, and not seek to obtain confidential information from patients. *Separate Confidentiality form signature required
2. My services are donated to the hospital without contemplation of compensation or future employment, and given with humanitarian or charitable reasons.
3. I understand it is a crime to solicit business for attorneys. I shall not solicit any business for attorneys or insurance companies "for compensation" both on and off hospital property. I shall report all known occurrence of solicitation to the Volunteer Coordinator.
4. I shall not attempt to sell goods or services, request contributions or solicit persons to sign petitions of any kind on hospital premises, unless I receive authorization from the Volunteer Coordinator.
5. I shall submit to examinations which may include chest x-rays, skin tests, appropriate laboratory tests and/or immunizations that may be necessary as a part of my volunteer service. * Separate Screening form signature required
6. I shall be punctual and conscientious, conduct myself with dignity, courtesy and consideration of others and endeavor to make my work professional in quality.
7. I shall make my best effort to fulfill my commitment to Memorial Hospital of Lafayette County by completing all assignments that I accept.
8. I shall at all times uphold the philosophy and standards of Memorial Hospital of Lafayette County.
9. I shall attempt to resolve any problems related with my volunteer activities with the Volunteer Coordinator.
10. I understand that the Volunteer Coordinator reserves the right to terminate any volunteer status as a result of (a) failure to comply with hospital policies, rules or regulations; (b) absences without prior notification; (c) unsatisfactory attitude, work or appearance; or (d) any other circumstances which, in the judgment of the Volunteer Coordinator, would make continued services as a volunteer contrary to the best interests of Memorial Hospital of Lafayette County.

I have read the above conditions and I agree to be bound by them; It is agreed that any misrepresentation by me on this application will be sufficient cause for cancellation of this application and/or separation from service as a volunteer. I give the organization the right to investigate all references and to secure additional information about me if related to the volunteer position. I hereby release from liability the employer and its representatives for seeking such information and all other persons, corporations or organizations for furnishing such information.

Signature of Applicant: _____ Date: _____