



SHERIDAN MEMORIAL HOSPITAL

Volunteer Application

Volunteer Services -- Patty Forister (307) 675-2620

Date: _____

AUX: _____

Name: _____
(Last) (First) (Middle)

Home Address: _____ Phone: _____

Business Address: _____ Phone: _____

Birthday: _____ Referred by: _____

Prior Experience:

Volunteer: _____

Employment: _____

Special Interests & Hobbies: _____

If there is a special request for volunteer help would you like to be called? Yes No

Person to call in the event of an emergency: _____
Address _____ Phone: _____

What is your use of drugs/alcohol? _____

Are you currently under a doctor's care? If so, with whom and for what reason?

What medications are you taking? _____

Have you ever been convicted of a felony? If yes, please explain: _____

Why do you want to be a volunteer? _____

How did you learn of the Sheridan Memorial Hospital Volunteer program? _____

What skills or training do you have which might be utilized in your volunteer assignment? _____

What would you NOT be willing to do? _____

What days and hours are you willing to designate for volunteer work at Sheridan Memorial Hospital?

Do you like patient contact? Yes No Remarks: _____

List three references. Please include addresses and telephone numbers.

Thank you for your interest in volunteering at Sheridan Memorial Hospital!



VOLUNTEER AGREEMENT

As a Volunteer at Sheridan Memorial Hospital, I will be punctual and conscientious in the fulfillment of my duties and will accept supervision graciously.

I agree to dress neatly and have a pleasant rapport with the people I work with and others with whom I come in contact.

I will ask the Volunteer Services Coordinator or the personnel of the department if I do not understand an assignment.

If unable to fill my placement commitment, I understand it is my responsibility to try to find a substitute. If unable to do so, I will contact my Department Manager or the Volunteer Services Coordinator 24 hours in advance except in case of emergency.

I will conduct myself with dignity, courtesy and consideration, honoring the volunteer policies whenever I am on duty.

I will consider CONFIDENTIAL, all information which I may hear directly or indirectly concerning a patient, doctor or any member of personnel.

I will not seek information in regard to a patient.

I will take any problems, criticism or suggestions to the Volunteer Services Coordinator.

Signature

Date

CONFIDENTIALITY STATEMENT

I acknowledge that in the course of my experience at Sheridan Memorial Hospital, I may become aware of certain patient related information that must be kept confidential. I am aware of the need to respect patient privacy and confidentiality and I hereby pledge to protect these patient rights. I further acknowledge that the unauthorized disclosure of such confidential information may result in disciplinary or legal action.

Print Name

Signature

Date