



**ADULT
VOLUNTEER SERVICES
APPLICATION**
939 Caroline Street
Port Angeles, WA 98362

PERSONAL INFORMATION

First _____ Middle _____ Last _____

Date of Birth _____ Last 4 digits of Social Security # _____

Driver's License # _____ Photo Copy Yes No

Email _____

Address _____

City _____ State _____ Zip _____

Phone _____ Secondary Phone _____

Do you speak any foreign languages? No Yes- If yes, please list. _____

EMERGENCY INFORMATION

Emergency Contact _____

Relationship to you _____ Home Phone _____

Work Phone _____ Cell Phone _____

QUESTIONNAIRE

1. Why are you interested in volunteering? _____

2. Previous Volunteer Service:

Organization (s): _____

Please list any hobbies, skills, or interest that you think may be of value in your volunteer service:

3. Please check all areas that you are interested in working in the hospital:

- | | |
|--|---|
| <input type="checkbox"/> Information Desk/Lobby Greeter | <input type="checkbox"/> Med/Surg. Pediatrics |
| <input type="checkbox"/> Gift Shop | <input type="checkbox"/> Education |
| <input type="checkbox"/> Surgery – Family Information Desk | <input type="checkbox"/> Hospital Events |
| <input type="checkbox"/> Emergency Department | <input type="checkbox"/> Other work, please list ways you can help: _____ |
| <input type="checkbox"/> Clerical | <input type="checkbox"/> If a position is available, I would be interested in working in Sequim |
| <input type="checkbox"/> Dietary | |
| <input type="checkbox"/> Patient/Item Transport | |
| <input type="checkbox"/> Dietary | |

EDUCATION & WORK EXPERIENCE

Education: Check highest level High School: 9 10 11 12 GED

Name & State _____

If under 19, please list your primary interest of study/career goals _____

College: 1 2 3 4 Graduate School 1 2 3 4

Degree/Major _____

Employment Experience:

Have you ever worked at a hospital? Yes No

Last Place of Work – if any: _____

Business Name _____

Address _____ Phone _____

Position _____ Supervisor's Name: _____

REFERENCES:

Please include references for any current or former job supervisors, teachers or clergy. Family members, relatives and friends may not provide recommendations.

Reference 1 Name: _____ **Phone:** _____

Relationship to you: _____ **Business Name:** _____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Reference 2 Name: _____ **Phone:** _____

Relationship to you: _____ **Business Name:** _____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

OTHER:

1. Have you ever been convicted of a felony? Yes [] No []
2. Have you ever been convicted of a misdemeanor? Yes [] No []

If 'Yes' to either question, please describe the conviction(s) in detail, including dates.

3. How did you hear about this volunteer program? _____

4. Do you hold any special medical or clinical certifications or licenses, or had medical training of any type? No [] Yes [] – Please list: _____

5. When can you start volunteering? _____

6. Check when you wish to volunteer. Most shifts are 3 hours.

- [] Monday _____ to _____
[] Tuesday _____ to _____
[] Wednesday _____ to _____
[] Thursday _____ to _____
[] Friday _____ to _____
[] Saturday _____ to _____

PLEASE READ THE FOLLOWING BEFORE SIGNING:

Your placement as a volunteer with Olympic Medical Center is dependent upon the acceptance by Volunteer Services and completion of the hospital health requirements along with the report from the Washington State Patrol request for criminal history information (Child/Adult Abuse Information Act RCW 43.43.830). Olympic Medical Center is required to run a check on all volunteers and employees.

I hereby declare that all the information I have given above is true to the best of my knowledge. I further understand that my volunteering is contingent upon checking of references furnished. I consent to and authorize the hospital and its personnel to request any information concerning work and personal references as indicated on this application for volunteering. I hereby release all parties and persons connected with any request for information from all claims, liabilities, and damages for whatever reason arising out of furnishing such related information.

I am aware that the participation in the Volunteer Program may have risk of injury or illness. I understand there is no compensation or insurance benefit provided to me in the event that become injured or ill in the course of my volunteering. I acknowledge and accept the risks inherent to the Volunteer Program and working in a healthcare setting, and with this knowledge in mind, agree to participate in the Volunteer Program.

I understand I will not be paid for my volunteer services. I also agree to abide by ALL volunteer and hospital program policies and procedures.

_____ I give my permission to be photographed and used for press releases
Initials

_____ I give my permission to share your contact information with the Volunteer Coordinator, OMC volunteers and Auxiliary.
Initials

Applicants Signature

Date

**Auxiliary Membership \$5.00 Annually
Check here if interested _____ Paid _____

Please return signed application to:

**Olympic Medical Center
939 Caroline Street
Port Angeles, WA 98382**

**If you have any questions, please contact Kathy Coombes, Volunteer Coordinator
(360) 565-9110**

**OR
kcoombes@olympicmedical.org**