Rush Memorial Hospital
1300 North Main Street, PO Box 608
Rushville, IN 46173
765-932-7486

Name: ____________________

Address: ____________________

Phone: ____________________ Cell Phone: ____________________

Date of Birth: ____________________

IN CASE OF AN EMERGENCY, PLEASE NOTIFY:

Name: ____________________

Phone: ____________________

Relationship: ____________________

List any accommodations necessary for you to perform volunteer duties:

____

EDUCATION: Grade School: 6 7 8 High School: 1 2 3 4 College: 1 2 3 4

Other Education: ____________________

Occupation: ____________________ ☐ Full-Time ☐ Part-Time

Employer: ____________________ Retired: ☐ Yes ☐ No

Phone: ____________________ May we call you at work? ☐ Yes ☐ No

Have you ever been convicted of a felony? ☐ Yes ☐ No

PREVIOUS AND PRESENT VOLUNTEER EXPERIENCE: ____________________

____

Agency: ____________ Duties: ____________ From: ________ to: ________

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MEMBERSHIP IN PROFESSIONAL OR COMMUNITY ORGANIZATIONS:

____

____

____

PERSONAL OR PROFESSIONAL REFERENCES: (Please exclude relatives.)

Name: ____________________ Phone: ____________________ Relationship: __________________

Name: ____________________ Phone: ____________________ Relationship: __________________

Name: ____________________ Phone: ____________________ Relationship: __________________

AVAILABILITY:

On the chart below, please check any shifts for which you would be able to accept a volunteer assignment. This does not necessarily commit you to multiple assignments, but will help us in selection of placement options.

	MON	TUE	WED	THUR	FRI
MORNING					
AFTERNOON					

ARE YOU WILLING TO SUBSTITUTE? ☐ Yes ☐ No

SKILLS AND EXPERIENCE:

Some of our volunteer assignments utilize specific skills. Please circle any you have and are willing to share with Rush Memorial Hospital.

Typing Filing Photocopying Computer Music Other ____________________________

If I am accepted as a volunteer, I agree to sign a confidentiality statement. I understand the hospital reserves the right to terminate my volunteer status as a result of failure to comply with hospital policies, rules, and regulations, and/or unsatisfactory work, attitude or appearance.

____

Signature Date

PERMISSION FROM PARENTS OR GUARDIAN IF VOLUNTEER IS UNDER AGE OF 18

Permission is granted for ______________________________ to join the RMH Volunteer Program. I understand that I will be responsible for providing transportation to and from the hospital. His/her health is such that I believe he/she is physically able to fulfill the obligations he/she is assuming. I further understand that my child may be required to purchase a uniform to participate in the program and have a TB test.

____

Signature of parent or guardian Date