



## PARMA HOSPITAL ADULT VOLUNTEER APPLICATION

Full Name: \_\_\_\_\_  
Last Name First Name Miss/Mrs./Ms./Mr. Spouse Name

Address \_\_\_\_\_ Apt. No. \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Primary Phone ( ) \_\_\_\_\_ Business Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Birthdate: Month \_\_\_\_\_ Day \_\_\_\_\_

Contact in Case of Emergency: \_\_\_\_\_ Relationship: \_\_\_\_\_

Primary Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

Personal Physician: \_\_\_\_\_ Phone No. ( ) \_\_\_\_\_

**PERSONAL REFERENCES:** Please do not use family members as a reference. Be sure to include the full name, address, and telephone number for each reference.

1. Name: \_\_\_\_\_ Phone No. ( ) \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

E-mail: \_\_\_\_\_

2. Name: \_\_\_\_\_ Phone No. ( ) \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

E-mail: \_\_\_\_\_

Why would you like to volunteer at this hospital? \_\_\_\_\_

Please list who referred you: \_\_\_\_\_

### Indicate Type of Volunteer Work Preferred

- { } Direct patient contact (e.g., Nursing Unit, Patient Transportation, Radiology, etc.)
- { } Limited patient contact (e.g., Information Desk, Surgery Waiting Room, etc.)
- { } No patient contact (e.g., Gift Shop, Coffee Shop, Clerical/Office Work, etc.)

### Indicate Activity Level Preferred

- { } Can tolerate considerable walking/standing over a period of hours
- { } Can tolerate a little walking/standing over a period of hours
- { } Sedentary position required

Do you have any physical limitations? If so, please list: \_\_\_\_\_

**CONFIDENTIALITY STATEMENT:** All information concerning patients is confidential. Breach of confidentiality could result in a lawsuit against the Hospital and against the individual revealing private information. A State Privacy Act places restrictions on the release of certain information. Revealing that a person is a patient in the Hospital without their consent is also a breach of confidentiality.

**DISMISSAL:** The Executive Committee and the Manager of Volunteer Services, in agreement, have the authority to dismiss a volunteer. This may occur if they feel the service of a particular volunteer is detrimental to University Hospitals Parma Medical Center, and/or any patient, employee, visitor or staff member or that the volunteer has not met the requirements of the volunteer program.

**TERMINATION:** To quit a service or to change to another service area, notify your Chairman.

**PLEASE NOTE:**

- Volunteers do not take the place of salaried staff at University Hospitals Parma Medical Center. Volunteer service does not lead to paid employment.
- Your signature indicates your approval for verification of references. The organization is NOT obligated to provide a volunteer position nor are you obligated to accept the volunteer position offered.
- Opportunities for volunteers are provided without regard to race, color, national origin, age, religion, sex, or disability.
- The above information is accurate and correct to the best of my knowledge.

Volunteer Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Interviewer: \_\_\_\_\_ Date: \_\_\_\_\_