



*Volunteer Services
 200 StoneCrest Blvd.
 Smyrna, TN 37167
 Phone: (615) 768-2200 or 768-2201
 Fax: (615) 768-2203*

Volunteer Application Form

The information on this form will help us to find the most satisfying and appropriate volunteer service for you. Your cooperation in completing it is appreciated.

Name _____ Date _____
 (Last) (First) (Middle)
 Address _____ City _____ State _____ Zip _____

Cities/States in which you have lived and/or worked for past seven (7) years:

_____	_____	_____
City	State	County (if known)
_____	_____	_____
City	State	County (if known)
_____	_____	_____
City	State	County (if known)
_____	_____	_____
City	State	County (if known)

Home Phone _____ Work Phone _____ Other Phone _____

E-Mail Address _____ Social Security Number _____

If Presently Employed, Name of Firm _____ Phone _____

Position _____ Work Hours & Days _____

Contact In Case of Emergency:

_____	_____	_____	_____
(Name)	(Relationship)	(Home Phone)	(Work Phone)

Family Physician _____ Phone _____

Limitations Related to Health _____

How did you become interested in our Volunteer Program?

Have you volunteered for this organization before? Yes _____ No _____

Education (Circle last year completed) Grade 6 7 8 High School: 1 2 3 4 College: 1 2 3 4

Volunteer Experience Summary: _____

Work Experience Summary _____

Indicate Hobbies/Skills/Special Interests/Foreign or Sign Language Skills:

Please give any other information you feel would assist us in reviewing your application:

Which would be the best time for you to volunteer? (Please circle your choice.)

Morning (8:00 a.m.-12:30 p.m.) **Afternoon** (11:00 a.m.-4:30p.m.) **Evenings** (4:30-8:30 p.m.) **All Day**

What days of the week do you prefer to volunteer? (Please circle your choice.)

Sunday Monday Tuesday Wednesday Thursday Friday Saturday

REFERENCES: Please list below references we may call. These should be employers, former employers, clergy, businesspeople, teachers/instructors, etc. (NOTE: References may **not** be family members.)

1. NAME _____ PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

E-mail _____

2. NAME _____ PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

E-mail: _____

3. NAME _____ PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

E-mail: _____

StoneCrest Medical Center Volunteer Services

STATEMENT OF UNDERSTANDING

I hereby express my intention and desire to participate in the StoneCrest Medical Center Volunteer Services Program.

I understand that it is my responsibility to read the rules and regulations of StoneCrest Medical Center Auxiliary Handbook/Bylaws and the job description of my volunteer assignments. I agree to abide by these regulations and to perform my assigned volunteer duties to the best of my ability.

I understand that any offer of volunteer opportunities at StoneCrest Medical Center will be conditional upon verification of my references, attendance at a general orientation program, and any other requirements specified by StoneCrest Medical Center and the StoneCrest Medical Center Auxiliary.

By submitting this application, I authorize StoneCrest Medical Center or its representatives to investigate and verify any and all of the information contained in this application, including a criminal background check and inquiry into the GSA and OIG sanction list. I also authorize all references listed herein to verify any and all information I have provided and to give any additional information in response to reference questions intended to determine my suitability for volunteering. I hereby release all investigators, individuals and StoneCrest Medical Center from any liability for providing or receiving such information.

I wish to donate my services to the hospital, and I understand that at no time shall there exist an employer-employee relationship between myself, as a volunteer, and the hospital.

I further understand confidentiality must be maintained on patient and family information.

Signature

Opportunities for Volunteers are provided without regard to
Religion, Creed, Race, National Origin, Age or Sex.

FOR OFFICE USE ONLY

Orientation Date _____ TB Test _____

Assigned To _____

Days/Hours of Work _____

Director's Comments: _____

DISCLOSURE AND AUTHORITY TO RELEASE INFORMATION

I understand that in processing my application with StoneCrest Medical Center an investigative consumer report may be conducted to obtain and verify information relating to my past activities and background. Information may include, but is not limited to: criminal records, motor vehicle records and any data provided on this application or during the interview process.

My current employer may be contacted (if applicable): YES NO

I authorize the appropriate individuals, companies, institutions or agencies to release information, and I release them from any liability as a result of such inquiries or disclosures.

I further understand and waive my right of privacy in this investigation and release and hold harmless **StoneCrest Medical Center** and its agent, **Verified Credentials, Inc.**, from any liability.

An investigative consumer report may be generated summarizing this information. I have a right under the "Fair Credit Reporting Act" to obtain a copy of this report by providing proper identification and directing a written request to Verified Credentials, Inc., 20890 Kenbridge court, Lakeville, MN 55044 (1-800-473-4934). I may also obtain a copy of this report by checking the "YES" box below.

If employed in Minnesota, California, or Oklahoma,
I would like a copy of any report regarding me. YES NO

I hereby certify that all the statements and answers set forth on the application form and/or my resume are true and complete to the best of my knowledge, and I understand that if any statements and/or answers are found false or the information has been omitted, such false statements or omissions may be cause for rejection or termination of my employment or application. **PLEASE PRINT!**

Legal Last Name	Legal First Name	Legal Middle Name/Initial
-----------------	------------------	---------------------------

Street Address

City

State

ZIP

Please list any additional cities and states in which you have lived and/or worked during the past 7 years:

City

County (if known)

State

Other names used:

Driver's License #

State Issued

Expiration Date

Date of Birth

I AUTHORIZE A PHOTOCOPY OF THIS RELEASE TO BE ACCEPTED WITH THE SAME AUTHORITY AS THE ORIGINAL AND IF EMPLOYED BY THE ABOVE-NAMED COMPANY, THIS RELEASE WILL REMAIN IN EFFECT THROUGHOUT SUCH EMPLOYMENT.

Signature

Social Security Number

Date