



VOLUNTEER APPLICATION

Name _____

Home Address _____ E-Mail Address _____

City _____ State _____ ZIP _____ Cell Phone _____

Are you under 18 years old? Yes/No (circle one) If so, birth date _____

EDUCATION

Name of last school attended _____ Highest Grade/Level Achieved _____

WORK EXPERIENCE – Present or last employer

Employer _____ Dates _____

Address _____

Position & Duties _____

VOLUNTEER EXPERIENCE

Agency _____ Address _____

Duties _____ Dates _____

PERSONAL REFERENCES – Other than relatives (Please Print Clearly)

Name	Address	City/State/Zip	Phone
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1. _____

2. _____

Please state why you are interested in becoming a volunteer.

Name any specific area where you are interested in serving, ie. Greeter, Office, Nursing Floor, Pastoral Care, Mature Advantage Club, etc.

Within the past seven years, have you either (1) been convicted by any court, including court of military justice, of a felony, or (2) been released from prison following conviction of a felony? (For purposes of this application, consider felonies to include any crime which is punishable by imprisonment or execution.)

Yes No

IN CASE OF EMERGENCY, the hospital should notify whom:

Name _____ Address _____

Phone _____ Relationship _____

HOURS AVAILABLE FOR VOLUNTEERING:

List day(s) you prefer to work _____ Hours preferred _____

Attestation for All Volunteer Applicants:

I hereby certify that all answers given by me on this application are true to the best of my knowledge. I authorize West Tennessee Healthcare, Inc. to contact references whom I have listed on the application for the purpose of obtaining information about me. I also authorize West Tennessee Healthcare, Inc. to check my criminal record for the purpose of investigating any past convictions that could prohibit certain areas of volunteer assignment. I release West Tennessee Healthcare, Inc. from any liability based upon such. I understand that if selected as a volunteer, I will be considered unpaid staff, and will be responsible for adhering to the policies and procedures of West Tennessee Healthcare, Inc.

Signature _____ *Date* _____

Return application by mail to:
Katie Chandler, Customer Excellence Dept.
Jackson-Madison County General Hospital
620 Skyline Drive
Jackson, TN 38302

Or Fax to 731-541-5168.

Or Email to katie.chandler@wth.org