



Volunteer Application

Thank you for your interest in volunteering with our hospital. Volunteers play a vital role in supporting patients, families, and staff.

Our Mission Statement: *Christ's healing mission of compassion empowers us to be for others through quality and excellence.*

Our Vision Statement: *We are committed to being the preferred health and wellness provider; transforming lives through faith-based, compassionate care.*

Personal Information

Full Name: _____ **Date of Birth:** ____ / ____ / ____

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

Main Phone Number: _____ **Email Address:** _____

In Case of Emergency, Please Notify: _____

Name	Phone number	Relation
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Availability

Please indicate the days and times you are generally available to volunteer.

Days Available (check all that apply): Monday Tuesday Wednesday Thursday Friday Saturday Sunday

Preferred Shift Times: Morning Afternoon Evening

Do you have any physical condition or medical problem which may limit your ability to perform the work of a Volunteer? YES ___ NO ___ If YES, please explain: _____



Areas of Interest

Please select the volunteer areas you are interested in (placement based on availability and hospital needs):

- Patient Support / Rounding
 - Information Desk / Greeter
 - Clerical / Administrative Support
 - 800 Gift Shop
 - Pastoral Care Support
 - Transport / Escort Services
 - Special Events
 - Other (please specify): _____
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Education & Experience

Highest Level of Education Completed: _____

Current School or Employer (if applicable): _____

Relevant Skills, Certifications, or Experience (medical, customer service, spoken languages, etc.):

Volunteer History

Have you volunteered before?

- Yes No

If yes, please describe your previous volunteer experience(s): _____



Background & Health Requirements

To ensure the safety of our patients and staff, volunteers will be required to complete the following:

- Background check required for ages 18 and above
- Flu Immunization Verification or Approved Exemption Form
- TB Test Blood Draw

Do you agree to comply with these requirements?

Yes No

References

Please provide one or two references who can speak to your character or work ethic.

Reference 1: Name: _____ Relationship: _____

Phone or Email: _____

Reference 2: Name: _____ Relationship: _____

Phone or Email: _____

Statement of Interest

Please briefly explain why you would like to volunteer at our hospital:



Applicant Agreement and Commitment to Volunteer

I certify that the information provided in this application is true and complete to the best of my knowledge. I understand that submitting this application does not guarantee placement as a volunteer and that acceptance is contingent upon meeting hospital requirements.

I commit to being a volunteer and live according to the Mission, Vision, and Core Values of Deaconess Memorial Medical Center. I will abide by the expectations outlined in the Volunteer Guidelines. I agree to work with the Volunteer Coordinator and to accept the volunteer position that fits my gifts, talents and meets the needs of Deaconess Memorial Medical Center.

Applicant Signature: _____ **Date:** _____

Parent/Guardian Consent: My child _____ has my consent to serve as a volunteer at Deaconess Memorial Medical Center. To my knowledge, my child is healthy and physically able to fulfill the duties to which they are assigned. In the event of medical intervention needed, I consent for the provider/designee to use their best judgment as to best care for my child.

Parent/Guardian Name (printed): _____

Parent/Guardian Signature: _____ **Date:** _____

Please return this application to the Volunteer Coordinator at

DMMCVolunteers@deaconess.com or at the

Memorial Medical Center Foundation located at 709 W 9th St, Jasper, IN 47546