



ACMH HOSPITAL AUXILIARY

One Nolte Drive
Kittanning, PA 16201
724-543-8142

Website: www.acmh.org (click on volunteers & Auxiliary)

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Adult Volunteer Application

NAME _____ PHONE _____

ADDRESS _____ CITY _____ ZIP _____

E-MAIL ADDRESS _____ DATE OF BIRTH: _____

EDUCATIONAL BACKGROUND

SHIRT/SMOCK SIZE: _____

High School _____

Business school _____

College _____

Other _____

Have you worked in a hospital before? _____

Employee _____

Volunteer _____

What employment experience have you had? Type of work? _____

_____ Length of time _____

Do you have previous volunteer experience? _____

List special skills, training, interest, hobbies _____

Computer experience _____ Bookkeeping _____ Filing _____

Will you be out of town at certain seasons? _____

How many hours can you serve regularly each week? _____

Would you be available to assist with special one-day events? (Health fairs, fundraiser sales, etc.)? _____

Proof of personal health insurance is required.

Act 34 Clearance/criminal background check will be done.

What interested you in volunteering? _____

What assignment area are you interested in? _____

AVAILABILITY FOR SERVICE: **Check preferred and secondary choices for regular service**

DAY	MORNING	AFTERNOON	EVENING
MONDAY			
TUESDAY			
WEDNESDAY			
THURSDAY			
FRIDAY			
SATURDAY			
SUNDAY			

When are you available to begin a volunteer assignment? _____

REFERENCES: Please list two non-related persons who have known you at least one year:

1.

Name	Occupation	Phone
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Address _____

2.

Name	Occupation	Phone
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Address _____

DATE OF APPLICATION _____ **SIGNATURE** _____

FOR OFFICE USE ONLY:

Date of interview _____ Assigned to _____ Starting _____

Source of referral _____

Remarks: