ACMH HOSPITAL AUXILIARY

ACMH
One Nolte Drive
Kittanning, PA 16201
7245438142
ACMH.org/volunteer

Adult Volunteer Application

NAME ____ PHONE ___________________________.

ADDRESS _____________________________________ CITY___________________ ZIP____________________

E-MAIL ADDRESS_______________________________________ DATE OF BIRTH_________________________

Do you have previous volunteer experience?____

How long are you available to volunteer? (3 mos./6 mos./9 mos./ I yr)______________________________ ☐

What day/days of the week do you prefer to volunteer? ____

Any special skills, training, hobbies, or interests? ____

I, ___________________________________ will follow the rules and regulations set up by ACMH Hospital and its Auxiliary. If I do not abide by them, I understand that I will be subject to dismissal. I will keep confidential any patient information that I may have access to as I do my volunteer assignment. I understand that participation in the program is entirely voluntary and requires participants to abide by applicable rules and standards of conduct. I release ACMH and related parties from any and all claims or liability arising out of this participation. By signing you agree to allow yourself to be photographed and/or timed for publicity and advertising in any and all platforms.

Signature (do not print)__________________________________ Date ______________

Proof of personal health insurance is required.
Act 34 clearance/ criminal background check will be done.

Please return completed applications to the front desk of ACMH or to sterlings@acmh.org