Adult – 18 yrs. or older

When completing this application please Print Info. in black ink

Arrowhead Regional Medical Center
Department of Volunteer Management
400 N. Pepper Avenue
Colton, California 92324
(909) 580-6340

ADULT VOLUNTEER APPLICATION

_____ _____
Last Name, First Name, Middle Initial Month / Day of Birth

_____
Home Address ~ Number, Street, Apt. # City State Zip Code

_____
Mailing Address ~ Number, Street, P. O. Box City State Zip Code

(____)_____ (____)_____ (_____)_____
Home Telephone Number Cell Telephone Number Work Telephone Number / Ext.

If you are fluent in any other Non-English language, please specify :

Language: _____ ☐ Speak ☐ Read ☐ Write

Language: _____ ☐ Speak ☐ Read ☐ Write

WORK EXPERIENCE

(Beginning with your current or most recent position. Please include any volunteer work.)

From: (Mo./Yr.) _____ To: (Mo./Yr.) _____	Title: _____ Company: _____ Paid ☐ Volunteer ☐ Brief description of your responsibilities: _____ _____
From: (Mo./Yr.) _____ To: (Mo./Yr.) _____	Title: _____ Company: _____ Paid ☐ Volunteer ☐ Brief description of your responsibilities: _____ _____
From: (Mo./Yr.) _____ To: (Mo./Yr.) _____	Title: _____ Company: _____ Paid ☐ Volunteer ☐ Brief description of your responsibilities: _____ _____

Are you currently enrolled in a post-secondary college or university program? Yes ☐ No ☐

If yes, can you provide documentation of same? Yes ☐ No ☐

Indicate the type of volunteer work you would prefer: _____

(Due to Liability Issue's – We do NOT participate in any type of hands-on patient care)

How did you hear about our program? _____

Have you ever been a volunteer at this hospital (A.R.M.C.) before? Yes ☐ No ☐

If yes, please indicate:

Date(s):_____ Position:_____ Department: _____

Emergency Notification: Person to notify in case of an emergency:

_____	_____	(____)_____
Name	Relationship	Telephone Number

I understand that if accepted as a volunteer at A.R.M.C. I must: comply with hospital policies, rules and regulations; maintain active dependable participation in the program; maintain satisfactory attitude, appearance and work performance levels; strictly observe hospital ethics and rules of confidentiality; and treat all patients, visitors and staff with dignity, kindness, understanding, and respect.

I understand that information obtained during the reference check will be limited to that appropriate to determining my suitability for particular types of volunteer work and that all such information will be kept confidential. I hereby give my permission to those individuals or organizations contacted for the purpose of this reference check to give their full and honest evaluation of my suitability of the described volunteer work and other such other information as they deem appropriate.

My services are donated to A.R.M.C. without contemplation of compensation or future employment and give with humanitarian, religious or charitable reasons.

I understand that failure to provide complete, accurate, truthful information on this application may be grounds for immediate dismissal from the program.

I agree to accept termination from the program at any time and for any reason, if in the judgment of the department director, my continued service as a volunteer is contrary to the best interests of the hospital.

_____	_____
Signature of Applicant	Date

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CONFIDENTIALITY STATEMENT

I understand and agree that in the performance of my duties as a volunteer of Arrowhead Regional Medical Center, I must hold medical information in confidence.

Further, I understand that intentional or involuntary violation of patient confidentiality,
including information contained in the patient medical records, may result in stringent disciplinary action against me, including immediate dismissal from the program.

_____ _____
Volunteer's Name (Please Print) Volunteer's Signature

_____
Volunteer Management Signature

I authorize the Arrowhead Regional Medical Center Volunteer Management to contact me if I am ill or hospitalized.

Yes_____ No_____

_____ _____
Volunteer's Name (Please Print) Volunteer's Signature

_____
Date

Arrowhead Regional Medical Center
Department of Volunteer Management

Emergency Information

_____ (____)_____
Last Name, First Name, Middle Initial Home Telephone Number

Health information that might be important in the event you require emergency treatment:

Medications You Take	Drug Sensitivities	Allergies

Special health concerns: _____

_____

_____

_____ (____)_____
Personal Physician Telephone Number

_____
Name of Clinic or Hospital

Person(s) to notify in an emergency:

Name	Relationship	Telephone Numbers	
		Home	Cell
		( )	( )
		( )	( )
		( )	( )

_____ _____
Signature of Volunteer Date