



4011 S. Monroe Medical Park Blvd
Bloomington, Indiana 47403
(812) 825-0802 Fax (812) 825-0750

VOLUNTEER APPLICATION

DOB _____

Date: _____ Preferred Nickname: _____ Social Security Number: _____

Last Name: _____ First Name: _____ M.I.: _____

Home Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

I prefer to receive calls at: Home Work Cell E-mail Address: _____

In case of an Emergency Notify: _____

Relationship: _____ **Phone #:** _____

Previous Volunteer Experience: _____

Please include the name and address of organizations where you previously volunteered:

Have you ever been found guilty of ANY misdemeanor, felony or forfeited bail in any court? Yes No

If yes, please explain: _____

Have you ever been involved in an abuse, mistreatment and/or neglect investigation by any facility or state agency (i.e., State Department of Health, Child Abuse Registry, or Department of Social Services)? Yes No

If yes, please explain: _____

Please indicate your available day(s) and hours:

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Morning							
Afternoon							
Evening							



4011 S. Monroe Medical Park Blvd
Bloomington, Indiana 47403
(812) 825-0802 Fax (812) 825-0750

VOLUNTEER APPLICATION

DOB _____

Service areas of interest:

A. _____

B. _____

C. _____

D. _____

References: Give the names of three persons (non-relatives) whom you have known at least one year.

Name	Address and Phone Number	Business	Years Acquainted

Volunteer Statement of Commitment: I understand that my services are donated to Monroe Hospital and that there is no payment for the services rendered under the Volunteer Program. I understand that volunteering at Monroe Hospital means a commitment of time and/or talent and that staff patients and families will depend on me.

Confidentiality Agreement: *I understand that any information I may obtain directly or indirectly concerning patients, families, visitors, staff, Monroe Hospital or affiliates will be held absolutely confidential. If I break confidentiality of patient and/or families I will be terminated from the volunteer program.*

Annual TB Skin Test and Education Review: I understand that I am responsible to complete an annual TB skin test at Hospital expense, and education review of Hospital and service area information.

Photo Release: I understand that a Hospital representative may take photographs of me for publications or volunteer services use during my volunteer time.

Drug Screen: I understand that submitting to a lawful drug or alcohol test may be required as a condition of volunteering and understand that refusal to promptly submit and cooperate with such testing prior to or during the time period of which I am a volunteer will result in termination from the Volunteer Program.

Background Check: I understand that the State Police will provide Monroe Hospital with any record I may have for conviction of any crime. I understand that I have a right to inspect my criminal history record and request correction of any inaccurate information. If I do exercise that right, I waive liability of the State Police and any State Police employee for any claim for damages arising from the dissemination of inaccurate information.

I have read and understand the above statements. I understand the written information and agree to abide by the rules, regulations and policies of Monroe Hospital-owned or -operated facility or clinical practice and the Volunteer Services Department. I understand that if I do not abide by rules, regulations and policies, I may be terminated from the volunteer program.

Volunteer Signature

Date

* For questions related to the Volunteer Program, please contact Ellen Miller at (812) 825-0915.