Fayette Medical Center

DCH Health System

Volunteer Application

- ☐ **Adult** *(over 18 years old)*
- ☐ **College Student**
- ☐ **Junior Volunteer** *(Minimum age of 14)*

Name: _____

Phone: (H)_____ (W)_____(C)_____

Address: _____
Street City State Zip

Email: _____Social Security #: _____Date of Birth_____
(MM/DD/YEAR)

Spouse name: _____ Phone: (H)_____ (C)_____

Address: _____City_____State_____Zip Code_____

In case of emergency, notify: _____Phone: (H)_____(C) _____

Education: (High School) 9 10 11 12 GED (College) 1 2 3 4 5 6+ years (Circle One)

Experience including organization name, dates, position held and reason for leaving:

Employment:_____

_____

_____

_____

Volunteer:_____

_____

_____

Community Organizations:_____

_____

_____

May we contact the agencies and/or employers listed above? Yes No (Circle)

Licenses, Special Skills, Interests, Foreign or Sign Language:_____

_____

VOLUNTEER HOURS ARE USUALLY SCHEDULED IN 4 HOUR SHIFTS MONDAY - SUNDAY.

Volunteer service area preferred: _____Patient _____Non-patient_____

Specific area desired, if known:_____

Days/Hours preferred:_____

Expected duration of service:_____

If selected as a hospital volunteer, what date will you be available to begin?_____

References (not relatives):

Name _____ Address _____ Phone _____

Name _____ Address _____ Phone _____

Name _____ Address _____ Phone _____

Have you ever been convicted of a crime? _____Yes _____No

If yes, explain_____

PLEASE READ CAREFULLY AND SIGN BELOW:

I certify that the statements made on this application are true and correct to the best of my knowledge and belief and hereby grant DCH Health System permission to verify such answers. I understand that false statements on this application may be considered sufficient cause for dismissal.

I will consider all information as confidential which I may hear directly or indirectly concerning a patient, physician, or any member of personnel and will not seek information in regard to a patient.

I pledge to be dedicated to the mission of DCH Health System and to abide by the Volunteer Department Policies and Procedures and the By-Laws of the Auxiliary.

_____ _____

Applicant Signature Date

Fayette Medical Center, 1653 Temple Avenue N., Fayette, AL 35555
205-932-1265

Fayette Medical Center

DCH Health System

Waiver and Authorization for Release of Felony Conviction & Driving Record

I hereby authorize and consent to the release of information concerning my past felony conviction and driving record to an authorized representative of DCH Health System. I understand and agree that by authorizing the release of this information to the Health System, I am waiving any and all rights, including privacy rights, which I may have concerning the release of this information to the Health System. I understand that this information will be considered in light of volunteer position(s) for which I am applying. The DCH Health System will retain such information on a confidential basis. I also understand it is the policy of DHC Health System to make offers to those applicants otherwise qualified for volunteer service upon a reasonable interpretation of the results of the felony conviction and driving record report.

_____

Drivers License #

_____ _____

Date Applicant Signature