



Volunteer Application

PERSONAL INFORMATION

Date: _____

Name: _____
Last First Middle Initial

Address: _____
Street City State Zip

Home Phone: _____ Date of Birth: ____/____/____

Cell Phone: _____

Email Address: _____ Pet Name (if applicable): _____

In case of an emergency, contact: Name _____
Address _____
Phone (home) _____ (work) _____

Please check if you are a current associate of Saint Mary's and/ or a Trinity Health Partner _____

Please list relatives or friends working or volunteering at Saint Mary's:

Name Department

Name Department

Previous work or volunteer experience: (most recent first)

Employer or Volunteer Organization Type of Work Paid or Volunteer Reason for Leaving

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Are you presently employed or attending school? Yes ___ No ___ If yes, indicate major: _____

Employer Address Phone Schedule

School Address Phone Schedule

EDUCATIONAL INFORMATION (Please circle highest level completed):

Grade School: 5 6 7 8 High School: 9 10 11 12 College: 1 2 3 4

Special Education/Training: _____

Computer Applications: _____

How did you become acquainted with Saint Mary's Health Care's Volunteer Program?

Volunteer Interest:

_____ Patient Contact Areas (i.e. patient transport, clinical unit, ambulatory setting)

_____ Non-Patient Contact Areas (administrative, information areas, non-clinical settings)

_____ List Minimum Volunteer Hours needed for Program/Curriculum (if applicable)

Specific Area(s) of Interest: 1st Choice _____ 2nd Choice _____

Available days: Morning _____ Afternoon _____ Evening _____

State why you would like to become active in the Saint Mary's Health Care Volunteer program:

Please give names of two references *not related to you* that you have known for at least one year:

1) _____ 2) _____

Commitment of Hours	
If accepted as a Saint Mary's Health Care Volunteer, I commit to volunteer at Saint Mary's Health Care for a minimum of four hours per week for six consecutive months or required commitment specified for a designated role or position.	
Signature	Date

OTHER INFORMATION

Have you ever been convicted of a criminal offense? Yes _____ No _____ If "yes," please explain offense(s):

Are there any felony charges pending against you? Yes _____ No _____ If "yes," please give location(s):

I authorize investigation of all statements contained in this application and certify that all information is accurate. As a volunteer of Saint Mary's Health Care Volunteer Program, I will be required to follow the personnel policies and rules of the hospital and that infractions of said rules may lead to dismissal. I understand the hospital reserves the right to change, revise, add or delete policies and rules as necessary, and I will be obliged to conform to such amendments. I understand that the position that I am applying for is an unpaid volunteer position.

Signature: _____ Date: _____



Saint Mary's Health Care, Grand Rapids, Michigan
Background Request Form- Fair Credit Reporting Act Notification

Personal Information <i>Print capital letters in the boxes Try not to touch the sides of the boxes</i>																											
First Name														Middle Name													
Last Name																											
Previous Legal Name (List only if used in last 7 years)																		Year Changed									
City of Current Address																		State					Zip Code				
Social Security Number														Date of Birth (month-day-year)													
Driver's License Number														State of Issue													

Previous Addresses <i>Start with most recent</i>																											
City														State					Zip Code								
City														State					Zip Code								
City														State					Zip Code								

The Fair Credit Reporting Act, as amended by the Consumer Reporting Reform Act of 1996, requires we advise you that for purposes of employment only, a Consumer Report may be obtained which may include information about your character, general reputation, personal characteristics, mode of living, past employment, school activities, driving record, criminal background, and Medicare/Medicaid history.

During the application process and any time during any subsequent employment, I hereby authorize a third party (chosen by Saint Mary's Health Care), Saint Mary's Health Care and/or its Affiliates to procure a Consumer Report. I understand such Consumer Report may include information regarding my character, general reputation, personal characteristics, mode of living, past employment, school activities, driving record, criminal background and Medicare/Medicaid history. I understand Saint Mary's Health Care and/or its Affiliates may obtain other relevant information, for purposes of employment only, and I agree to cooperate in such investigation and release from all liability or responsibility all persons, companies or corporations supplying such information. I authorize, without reservation, any additional party or agency contacted by the third party, Saint Mary's Health Care and/or its Affiliates to release this information without liability for damage incurred in giving it.

Signature: _____ Date: _____