Chino Valley Medical Center

VOLUNTEER SEVICES DEPARTMENT
Application for Volunteers Age 21 and older

Please print:

First Name: _____ Middle: _____ Last Name: _____

Address: _____ City: _____ Zip: _____

Home Telephone: _____ Cell Phone: _____

Date of Birth: _____ SSN: _____

Email Address: _____

Referred by: _____

Foreign Languages Spoken (if applicable): _____

Emergency Contact:

Person to call: _____

Relationship: _____ Telephone Number: _____

Do you have any relatives working for Chino Valley Medical Center?   Yes _____   No _____

If you do have relatives working for Chino Valley Medical Center, please indicate name(s), their department and relationship.

Name of Relative	Department	Relationship
Name of Relative	Department	Relationship

Volunteer Experience:
Please list any current or previous volunteer experience including assignment area, roles and duties.

_____

_____

Chino Valley Medical Center

Interests/Skills and Availability:
Areas of service preferred

_____

Please list your experience or skills that relate to the preference indicated above:

_____

_____

Please circle the days and shifts that you would be available to volunteer:

Mornings:	Mon.	Tues.	Weds.	Thurs.	Fri.	Sat.	Sun.
Afternoons:	Mon.	Tues.	Weds.	Thurs.	Fri.	Sat.	Sun.
Evenings: (3pm and later)	Mon.	Tues.	Weds.	Thurs.	Fri.	Sat.	Sun.

Comments:

_____

_____

TB Skin Test:

All volunteers are required to have a TB skin test before they begin working in the hospital.

Have you had a TB Skin Test in the last year?   Yes_____   No_____

If yes, can you provide a copy of the test results? Yes_____   No_____

_____

Please describe in detail why you are interested in volunteering at Chino Valley Medical Center:

_____

_____

_____

Chino Valley Medical Center

References:

Please print the contact information of two people we may contact (excluding relatives and roommates) who have known you for more than two years.

Name:_____Relationship:_____

Address:_____

City:_____State:_____Zip:_____

Telephone: _____ Alternate telephone: _____

How long have you known this person? _____

Name:_____Relationship:_____

Address:_____

City: _____State:_____Zip:_____

Telephone: _____ Alternate telephone: _____

How long have you known this person? _____

Have you been convicted of a felony? ☐Yes   ☐ No

If yes, please give the date, location and disposition of your case:

_____

_____

_____

SIGNATURE OF APPLICANT_____

Date: _____

✚ Chino Valley Medical Center

Background Check Consent:

For the protection of our patients, employees and volunteers, Chino Valley Medical Center (CVMC) performs criminal background checks for all potential employees and volunteers. Please sign the consent below authorizing CVMC to request this information.

I, _____ hereby give CVMC authorization to obtain information through Insites Investigations.

Name: _____ **Date:** _____

    Signature

For office use only:

TB Test Date: _____ **Read Date:** _____

Directory: _____

Timekeeper: _____

HR: _____

Accepted Date: _____

Orientation: _____

Dues Paid: _____

Guidelines Handbook: _____

Badge: _____ **Uniform:** _____

Notes: _____