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.

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____

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:

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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:

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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: ____

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