

MERCY MEDICAL CENTER-CLINTON
Volunteer Services Department
1410 North 4th Street
Clinton, IA 52732

Volunteer Application

Last Name _____ First Name _____

Address _____
Street City State Zip

Home Phone _____ email _____

Date of Birth _____ Education Completed _____

Do you have a record of founded child or dependent adult abuse? Yes _____ No _____
If yes, explain

In case of emergency on duty, who is to be notified?

Name _____ Relationship _____

Address _____ Phone _____

What days are you available _____ Hours _____

Would you be available for special projects or substitution? Yes _____ No _____

Employment/Volunteer History:

Job Title _____ Place _____ # of Years _____

Hobbies, skills, special interests _____

Which of the following services do you prefer?

<input type="checkbox"/> Knitting & Sewing	<input type="checkbox"/> Thrift Shop	<input type="checkbox"/> Nuclear Med Waiting
<input type="checkbox"/> Gift Shop	<input type="checkbox"/> Information Desk	<input type="checkbox"/> Patient Escort (Admit)
<input type="checkbox"/> Mail & Menu Delivery	<input type="checkbox"/> Coffee Bar	<input type="checkbox"/> Surgical Waiting
<input type="checkbox"/> Long Term Care	<input type="checkbox"/> Other	

Please list two references

Name _____ Phone _____

Name _____ Phone _____

The information provided in this application is true in all respects, without any willful omissions. I understand that if this application is false in any way I will be dismissed without notice regardless of when the false information is discovered.

As a volunteer, I

- Agree to attend the volunteer orientation and train until I am competent to perform the required duties
- Agree to comply with all the rules and regulations of the hospital and the Volunteer Department
- Understand that I may be dismissed from my duties for willful wrongdoing or negligence and/or performing duties outside of my service guidelines
- Agree to call my staffing chairman or volunteer director as soon as possible when I have scheduling changes

Confidentiality: It is the belief of this hospital that all medical, financial, and personal information pertaining to a patient is confidential and is protected from unauthorized viewing, discussion and disclosure. Therefore volunteers may look at, use, or disclose patient information **ONLY** as it relates to the performance of their duties. Any unauthorized viewing, discussion, or disclosure will provide grounds for immediate dismissal. Whenever it is questionable as to what information is confidential, it is your responsibility to discuss the matter with your supervisor before any breach of confidentiality occurs.

I acknowledge and have read the statements above and agree to abide by the expectations of the Department of Volunteer Services and Mercy Medical Center

Signature

Date