



**PERSONAL INFORMATION**

Birthdate: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex:  Male  Female

RACE/ETHNICITY (optional) – Please select one or more of the following:

- ETH1. American Indian or Alaskan Native
- ETH2. Black African American
- ETH3. Native Hawaiian or Other Pacific Islander
- ETH4. Hispanic or Latino
- ETH5. Asian
- ETH6. White (Non-Hispanic)
- ETH8. Other (Please specify): \_\_\_\_\_

Are you a U.S. Citizen? . . . . .  Yes  No

**VOLUNTEER REFERRAL METHOD**

How did you first hear about the Lee Memorial Health System Volunteer Program?

- REF1. Current/ Former Volunteer – Name: \_\_\_\_\_
- REF2. Former Patient/Family Member of a Patient
- REF3. Media (please specify): \_\_\_\_\_
- REF4. SHARE Club
- REF5. Physician
- REF6. Other (please specify): \_\_\_\_\_

**EDUCATION INFORMATION**

HIGH SCHOOL GRADUATE/GED:  Yes  No

COLLEGE DEGREE:  AA/AS  BA/BS  MA/MS  PhD  Other: \_\_\_\_\_

YEARS OF COLLEGE: \_\_\_\_\_ MAJOR(S): \_\_\_\_\_  
(College/University Students Only)

NAME OF COLLEGE/UNIVERSITY: \_\_\_\_\_ # OF SERVICE HOURS NEEDED: \_\_\_\_\_

**BACKGROUND INFORMATION**

Have you ever been convicted of, had adjudication withheld, or pled guilty or nolo contendere (no contest) to a criminal offense (misdemeanor or felony)? (We do criminal checks. Falsification or failure to disclose this or any other information on this application is grounds for termination. A conviction does not necessarily disqualify you from volunteer service.) . . .  Yes  No

If YES, please explain: \_\_\_\_\_

Have you ever been refused bond? . . . . .  Yes  No

If YES, please explain: \_\_\_\_\_

Have you previously been an employee/volunteer for the Lee Memorial Health System? . . . . .  Yes  No

If YES, provide dates of employment/volunteer service, location and name of supervisor: \_\_\_\_\_

**WORK EXPERIENCE, SKILLS AND ACTIVITIES:**

Are you currently employed? . .  Yes  No Work Schedule: \_\_\_\_\_

Retired? . . . . .  Yes  No

Occupation/Former Occupation: \_\_\_\_\_

Work Experience: \_\_\_\_\_

Volunteer Experience/Community Affiliations: \_\_\_\_\_

What do you hope to achieve as a volunteer? \_\_\_\_\_

**WORK PREFERENCES:**  Patient Contact  Non-Patient Contact  Information/Clerical

WORK TIMES:  Morning (ex. 8:00 AM-12:00 PM)  Afternoon (ex. 12:00-4:00 PM)  Evening (ex. 4:00-8:00 PM)

WORK DAYS:  Monday  Tuesday  Wednesday  Thursday  Friday  Saturday  Sunday  Any Day (flexible)

WORK AREA PREFERENCE: \_\_\_\_\_

I would like to assist with Special Events (ex: fundraisers, health fairs, recruiting events): . . . . .  Yes  No

**Dear Volunteer Applicant,**

Please complete the skills questionnaire which will assist us in finding a rewarding volunteer position. We will discuss which skills you prefer to utilize as a volunteer.

**SKILLS**

<b>FINANCIAL</b>	<b>SKILL</b>	<b>OFFICE / CLERICAL</b>	<b>SKILL</b>	<b>OTHER SKILLS</b>	<b>SKILL</b>
Accounting		Computer, Typing		Acting / Singing	
Banking		Copier, Fax, Filing, Mailing, Phone		Arts & Crafts	
Bookkeeping		Receptionist		Calligraphy	
Other:		Shorthand		Carpentry, Construction	
		Other:		Child Care	
<b>RETAIL / BUSINESS</b>	<b>SKILL</b>			Counseling	
Cashier		<b>COMPUTERS</b>		Driver	
Customer Relations		Microsoft Office		Educator	
Display		Microsoft Excel		Electrical	
Manager		Microsoft Word		Engineering	
Marketing		Microsoft Powerpoint		Food Services	
Sales		Microsoft Access		Fund Raising	
Other:		Networking		Gardening	
		Web Design		Human Resources	
<b>HEALTH CARE</b>	<b>SKILL</b>			Legal Service	
LPN		<b>COMMUNICATION</b>	<b>SKILL</b>	Musical Instrument	
Medical Assistant		Customer Service		Real Estate	
Medical Records		Foreign Language (Please specify: _____)			
Nurse Aide					
Physician		Photography		<b>PAST ORGANIZATION LEADERSHIP</b>	<b>SKILLS</b>
Radiology		Public Speaking		Board of Directors	
RN		Training		Chairman	
EMT, Paramedic		Writing / Publishing		Committee Member	
Other:				President	
		<b>PATIENT CARE SERVICES</b>	<b>SKILL</b>	Secretary	
<b>PROFESSIONAL</b>	<b>SKILL</b>	<i>as applicable to the hospital</i>		Treasurer	
CEO / President		Feeding Patient		Vice President	
Director		Massage / Back Rub		Other:	
Manager		Patient Transport			
Supervisor		Visiting / Listening			
Other:		Other:			

**HOBBIES:**


In the event of an emergency (disaster, hurricane, pandemic) would you be available to volunteer? . . . . .  Yes  No

Preference:  Child Care  Customer Service  Food Service  Office/Clerical  Patient Care

I would be interested in a Auxillary Board Leadership position . . . . .  Yes  No

***Thank you for your time and efforts***

***PLEASE READ AND SIGN:***

**IF ACCEPTED INTO THE LEE MEMORIAL HEALTH SYSTEM  
VOLUNTEER PROGRAM, I AGREE TO:**

- Hold as absolutely confidential all information that I may obtain directly or indirectly concerning patients and staff.
- Become familiar with LMHS' policies and procedures and uphold the Code of Excellence.
- Honor my commitment to a specific job assignment.
- Donate my services without contemplation of compensation or future employment.
- Be professional, conscientious and conduct myself with dignity, courtesy and consideration of others.
- Furnish the appropriate volunteer uniform and maintain a well-groomed appearance.
- Attend orientation and inservice training as scheduled.
- Carry out assignments in a professional manner and seek the assistance of my supervisor when necessary.
- Discuss any problems, criticism or suggestions with my service area supervisor.
- Work a specified number of hours on a schedule acceptable to LMHS.
- Adhere to the volunteer department's sign-in procedure.
- Be punctual and notify my supervisor if unable to work as scheduled and find a substitute according to the volunteer substitution policy.
- Honor the minimum commitment of volunteer service (three months) with the first 16-20 hours being a probationary period.
- I understand that the **Volunteer Resources Department** reserves the right to terminate my volunteer status as a result of (a) failure to comply with health system policies; (b) absences without prior notification; (c) unsatisfactory attitude, work or appearance, or (d) any other circumstances which, in the judgment of the department director, would make continued services as a volunteer contrary to the best interests of Lee Memorial Health System and its patients.
- I, the undersigned, consent to any (1) pre-volunteer testing/screening required by the hospital; (2) annual health testing required by Lee Memorial Health System.

I hereby certify that there are no misrepresentations concerning my personal and professional history. I am aware that mis-statements of material facts may cause me to be disqualified from holding a volunteer position in the Lee Memorial Health System. I have read each of the above conditions and agree to honor them.

Signature of Volunteer: \_\_\_\_\_ Date/Time: \_\_\_\_\_