Northeast Georgia Health System, Inc.
Volunteer Services
743 Spring Street
Gainesville, GA 30501-3899
Phone: (770) 219-1830
Fax: (770) 219-5408

2150 Limestone Pkwy, Ste. 222
Gainesville, GA 30501
Phone: (770) 219-8888
Fax: (770) 219-8887
Toll Free: (888) 572-3900

Volunteer Application

CIRCLE ONE

Mr. Mrs. Ms. Miss Dr.

LAST NAME ______ FIRST NAME ______ PREFERRED NAME ______ MI ______

STREET ADDRESS ______ CITY ______ STATE ______ ZIP ______

HOME PHONE ______ CELL PHONE ______ WORK PHONE ______

FAX ______ EMAIL ______ DATE OF BIRTH (MONTH / DAY) ______

Emergency Contact Information

LAST NAME ______ FIRST NAME ______ RELATIONSHIP ______

STREET ADDRESS ______ CITY ______ STATE ______ ZIP ______

HOME PHONE ______ CELL PHONE ______ WORK PHONE ______

NAME OF VOLUNTEER'S PHYSICIAN ______ PHYSICIAN'S PHONE ______

References: Please list 2- personal & former work (if applicable)

LAST NAME ______ FIRST NAME ______ MI ______

STREET ADDRESS ______ CITY ______ STATE ______ ZIP ______

HOME PHONE ______ WORK PHONE ______

LAST NAME ______ FIRST NAME ______ MI ______

STREET ADDRESS ______ CITY ______ STATE ______ ZIP ______

HOME PHONE ______ WORK PHONE ______

Employment History

EMPLOYER NAME ______ TITLE OF JOB ______ DATES OF EMPLOYMENT ______ PHONE ______

EMPLOYER NAME ______ TITLE OF JOB ______ DATES OF EMPLOYMENT ______ PHONE ______

If applicable for your volunteer position, please provide a copy of your licensure or certification

General Information

Are you now, or have you ever been a volunteer in any organization? YES NO If so, where? ______

Are you currently a college student? YES NO

Have you ever been convicted of any felony or crime other than a minor traffic violation? YES NO

Have you ever pled guilty or no contest to a crime or have any criminal charges pending? YES NO

If so, please explain: ______

General Health- Circle one below:

EXCELLENT GOOD FAIR POOR

How did you become interested in volunteering?
Circle all that apply

RADIO TV
NEWSPAPER FLIER
FRIEND OTHER
COMMENTS:

Schedule Preference

Please check the days / times that you are available:

	MON	TUES	WED	THUR	FRI	SAT	SUN
MORNING							
AFTERNOON							
EVENING							

Volunteer Information / Preferences

1. Circle the area in which you have interest or skills. This information is used to assist with placement.

   PATIENT / FAMILY CONTACT OFFICE SPECIAL PROJECTS

2. Please circle any special skills / talents that you are able / willing to share with patients, families, and Hospice:

   ART MASSAGE SEWING CALLIGRAPHY PET THERAPY SINGING

   COMPUTER SKILLS PHOTOGRAPHY VIDEO- RECORDING COOKING WRITING COSMOTOLOGY

   PUBLIC SPEAKING HAIRDRESSER SCRAPBOOKING PLAYING MUSICAL INSTRUMENTS NAIL TECH

   OTHER(S): ____

3. Do you speak any languages other than English? YES NO If yes, please identify: ______________________________________
4. Are you CPR certified? YES NO If yes, please indicate the expiration date and **provide a copy for your volunteer file**: _____________
5. Have you or are you currently serving in the military? YES NO If yes, please indicate the branch in which you served: ____________
6. If working with patients, are you able / willing to be in a home where there is smoking? YES NO
7. If working with patients, are you able / willing to be in a home where there are pets or animals? YES NO

   Please indicate the animals you are **unable** to be around: ____

To be completed by Hospice office: Glove Size: S M L Other: ___________________

For more information on other volunteer opportunities offered at NGHS, contact Volunteer Services at (770) 219-1830.

Auxiliary Membership Opportunity

The Medical Center Auxiliary is led by a board of Medical Center volunteers elected by the Auxiliary's Nominating Committee and approved by the Auxiliary Members. Membership dues are a minimum of $10 per year. The Medical Center Auxiliary donates all funds earned through volunteer efforts and Auxiliary projects to enhance services of Northeast Georgia Health System.

Agreement

I understand that volunteer applicants of Northeast Georgia Health System must fulfill all Volunteer Services requirements, including completion of application, interview, tuberculosis test, and proof of MMR if born 1957 or later. I authorize Northeast Georgia Health System to check any references requested and to perform a criminal background check for the purpose of acquiring reference information, and I release the Health System from any liability based on such releases. I also certify that the application information is accurate and that the Medical Center may accept volunteers in its sole discretion and may release a volunteer at any time from serving the organization.

____ ___________________________

SIGNATURE DATE

FOR OFFICE USE ONLY

Interview Date: _______________________________ Interviewers Initials: ___________

Comments: ____

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