SIERRA VISTA
REGIONAL MEDICAL CENTER

FOR AUXILLARY USE ONLY
FD DAY____FD EVE_____
ED______________
NICU CUDDLER_______
GIFT SHOP__________

APPLICATION FOR VOLUNTEER SERVICES

NAME:______________________________ **DATE:**______________

ADDRESS:______________________ **CITY:**____________ **STATE:**______ **ZIP:**__________

PERMANENT ADDRESS:______________________ **CITY:**____________ **STATE:**______ **ZIP:**__________

TELEPHONE: HOME______________________ **CELL**______________________

EMAIL:____

DATE OF BIRTHDAY: MONTH__________ **DAY**__________ **ARE YOU OVER THE AGE OF 18?** ☐ **YES** ☐ **NO**

☐ **EMPLOYED** ☐ **RETIRED** ☐ **COLLEGE STUDENT**

COLLEGE ATTENDING:____

AREAS OF INTEREST:

☐ **FRONT DESK DAY**

☐ **FRONT DESK EVENING**

☐ **GIFT SHOP**

☐ **NICU CUDDLER**

☐ **EMERGENCY SERVICES**

☐ **OTHER:** ______________________________

☐ **PHYSICAL THERAPY (PT)**

☐ **SPEECH-LANGUAGE THERAPY (ST)**

☐ **OCCUPATIONAL THERAPY (OT)**

☐ **VOLUNTEER PREFERENCE:** ______________________________

Please Note: Due to the popularity of the Cuddler and ER programs,volunteer openings in these areas are limited and can be ingrequent.

TIME AVAILABLE FOR ASSIGNMENT

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning							
Afternoon							
Evening							

IN EMERGENCY NOTIFY: NAME______________________________ **RELATIONSHIP:**______________

TELEPHONE: HOME______________________ **CELL**______________________________

Believing that **Sierra Vista Regional Medical Center** has need of my services as a volunteer, I agree:

A. To hold as absolutely confidential all information which I may obtain directly or indirectly concerning patients, families, doctors or personel, and I will not seek confidential information in regard to a patient and in accordance with Federal Law (HIPPA).

B. That my services are donated to Serria Vista Medical Center without contemplation of compensation or future employment, and given with out humanitarian or charitable reasons.

C. To abide by th Bylaws and Policies of Sierra Vista Regional Medical Center Volunteer Auxillary and to serve as a responsible member of the organization.

I certify that the answers given by me to the foregoing questions and statements are true, correct and without omissions.

Signature:______________________________________ Date:____________________

****Office Use Only****

Interviewed By______________________ Date______________________