

**St. Joseph's Hospital
and Health Center**

Volunteer _____
Student Intern _____
Non-employee _____

Placement Date _____ Department _____

VOLUNTEER SERVICES APPLICATION

Name _____ Phone _____

Address _____ Birth date _____

City/State/Zip Code _____

Email _____ How often do you check your email? _____

In case of emergency, call _____ Phone _____

High School _____ City _____ State _____

College _____ City _____ State _____

Degree obtained &/or course of study _____

Employment _____ City _____ State _____

Supervisor's name _____ Phone _____

Did someone refer you to the Volunteer Services Department? _____ If yes, whom?

Name _____ Phone _____

Why do you want to volunteer at the hospital? _____

Do you have any disabilities, such as hearing loss, physical problems, etc.? _____

Are you in counseling? _____ Do I have your permission to contact your counselor? _____

Do you have a particular type of volunteer work you would prefer? _____

Approximately how many hours a week are you available to do volunteer work? _____

Check the days you are available: M ___ T ___ W ___ T ___ F ___ S ___ S ___

Morning ___ Afternoon ___ Evening ___

Date _____