

SPECTRUM HEALTH VISITING NURSE ASSOCIATION
Volunteer Application

Name: _____ Date: _____

Address: _____

City: _____ County: _____ State: _____ Zipcode: _____

Telephone: Home _____ Work _____

Fax: _____ E-mail address: _____

Do you have available transportation? Yes No

Will you commit to volunteering one year or more? Yes No

How many hours per week are you available to volunteer? _____

Availability for volunteering (circle all that apply): Days Evenings Weekends

When will you be available to begin? _____

How did you hear about Visiting Nurse Volunteer Program? _____

Why would you like to volunteer? _____

Have you been convicted of a felony within the last seven years? Yes No

(conviction will not necessarily disqualify an applicant from volunteering)

If yes, please explain: _____

Previous volunteer experience: _____

Please provide any additional information such as special skills, training, experience, or qualifications you feel will be helpful to us in considering your application: _____

Last TB Skin Test/Chest X-ray: Date _____ Results: Negative Positive

PERSON TO NOTIFY IN CASE OF EMERGENCY:

Name: _____ Relationship: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip code: _____

TWO REFERENCES (please do not use family members)

Name: _____ Relationship: _____ Day Phone: _____

Evening Phone: _____

Address: _____ City: _____ State: _____ Zip code: _____

Name: _____ Relationship: _____ Day Phone: _____

Evening Phone: _____

Address: _____ City: _____ State: _____ Zip code: _____

PLEASE READ THE FOLLOWING STATEMENT CAREFULLY BEFORE SIGNING TO INDICATE YOUR UNDERSTANDING:

I certify that I am able to perform the essential duties of the volunteer position. In the event that I have a disability that will affect my ability to take an assignment, I will inform Visiting Nurse prior to volunteering so that reasonable accommodations can be made. Visiting Nurse reserves the right to require medical documentation regarding the need for accommodation.

I certify that the facts in this application are true and complete to the best of my knowledge and understand that falsified statements on this application may result in termination as a volunteer.

I understand and agree that my volunteering is for no definite period and may be terminated with or without cause, at any time, with or without notice.

I authorize investigation of all statements contained in this application. I release the listed references to provide you with any and all applicable information they may have. I hereby release these references from all liability for any information they may give to Spectrum Health Visiting Nurse.

Date

Signature