Patient Experience
One Hospital Drive
Lewisburg, PA 17837
P: 570-522-2144

EVANGELICAL COMMUNITY HOSPITAL
Excellence Every Day.

Volunteer Application

Date of Application: _____ /_____ /_____

Type of Volunteer: ☐ Adult ☐ College Student ☐ High School Student **Gender**: ☐ M ☐ F

_____ _____ _____
Last Name First Name MI

_____ _____
Address Line 1 Home Phone

_____ _____
Address Line 2 Cell Phone

_____ _____
City, State, Zip Preferred Name/Nickname (if applicable)

_____ _____ /_____ /_____
Email Address Date of Birth

NOTE: Please do not list an email address if it is not checked regularly. Email will be the primary form of communication.

Education and Work Experience

Level of Education: ☐ High School ☐ Associates ☐ Bachelors ☐ Graduate ☐ Doctorate ☐ Other

_____ _____ _____
Name of school attending/attended Major (if applicable) Grad. Month/Year

Have you ever been employed by Evangelical Community Hospital? ☐ Yes ☐ No

If yes, when? _____ Department: _____ Job Title: _____

Are you currently employed? ☐ Yes ☐ No ☐ Retired

_____ _____
Current/Previous Employer Job Title

Have you ever volunteered or are you currently volunteering elsewhere? ☐ Yes ☐ No

If yes, where? _____ Describe experience: _____

_____

_____

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Volunteer Interest and Availability

Why do you want to be a volunteer at Evangelical Community Hospital? _____

_____

_____

_____

What skills do you have to bring as a volunteer? (Ex: customer service, computer skills, problem-solving, etc.)

_____

_____

What are your volunteer areas of interest at Evangelical Community Hospital? _____

_____

What are your hobbies, talents, and interests? _____

_____

When would you be available to volunteer?

☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

☐ Mornings ☐ Afternoons ☐ Evenings

Have you ever volunteered at Evangelical Community Hospital before? ☐ Yes ☐ No

If yes, when? _____ Area: _____ Reason for leaving: _____

Have you ever pled guilty or been convicted of a misdemeanor or felony? ☐ Yes ☐ No

If yes, when did the offense occur? _____ Nature of crime: _____

Are you required to volunteer? ☐ Yes ☐ No

If yes, by whom? _____ Describe requirements: _____

Are you willing to commit to at least 50 volunteer hours in a 6-month period? ☐ Yes ☐ No

How did you hear about our Volunteer program? _____

If selected to be a volunteer, what size shirt would you need? _____

References

References should not be relatives or anyone who lives in your household. We prefer references to be from places of employment or places where you have previously worked or volunteered. Please note that we may contact your references only if you are selected as a volunteer.

Reference 1:

Full Name _____ Relationship to You _____

Mailing Address _____ Phone Number _____

City, State, Zip _____ Email Address _____

Reference 2:

Full Name _____ Relationship to You _____

Mailing Address _____ Phone Number _____

City, State, Zip _____ Email Address _____

In Case of Emergency

Please list up to two emergency contacts. At least one contact should be within 30 minutes of the Hospital.

Primary:

Full Name _____ Relationship to You _____

City and State _____ Home Phone _____

Work Phone _____ Cell Phone _____

Secondary:

Full Name _____ Relationship to You _____

City and State _____ Home Phone _____

Work Phone _____ Cell Phone _____

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Volunteer Requirements

Upon submission of this application, I hereby certify that all statements are true and correct to the best of my knowledge and belief. I hereby authorize Evangelical Community Hospital to investigate all statements and references contained in this application. I understand that misrepresentation or omission of facts called for herein will be sufficient cause for cancellation of consideration for volunteering or dismissal from Evangelical Community Hospital's volunteer program if I have become a volunteer.

If accepted to volunteer, I agree to abide by the rules and policies of Evangelical Community Hospital. I understand that if selected to be a volunteer, I will be required to complete the new volunteer process and attend orientation before beginning to volunteer. In connection with my application for volunteering with Evangelical Community Hospital, I will complete required paperwork and I understand that investigative background inquiries will be done, including state police criminal record checks and child abuse clearances in compliance with the Pennsylvania Act 153. I understand that as a new volunteer, I will be required to complete required health screenings and to be in compliance with Evangelical Community Hospital's vaccination and masking policies.

I acknowledge and understand that patient information is strictly confidential. All hospital employees and volunteers have an obligation to maintain patient confidentiality. Information concerning patients must never be discussed by volunteers or shared with other people inside or outside Evangelical Community Hospital. I will not seek information in regard to a patient. I understand that any violation of the Hospital's policies or failure to abide by the expectations may result in my dismissal as a volunteer at Evangelical Community Hospital.

_____
Printed Name

_____ _____
Signature Date

For applicants under the age of 18: Parent or Guardian signature is required.

_____ _____
Signature Date

Please mail or email your completed application to the Patient Experience department:

Email: **volunteers@evanhospital.com**

Mail: **Evangelical Community Hospital, Attn: Patient Experience, One Hospital Drive, Lewisburg PA 17837**