

**Volunteer Services**  
One Hospital Drive  
Lewisburg, PA 17837  
P: 570-522-2549



## Volunteer Application

**Date of Application:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Type of Volunteer:**  Adult  College Student  High School Student

**Title:**  Dr.  Mr.  Mrs.  Miss  Ms.  Other (please specify) \_\_\_\_\_ **Gender:**  M  F

\_\_\_\_\_  
Last Name First Name MI

\_\_\_\_\_  
Address Line 1 Home Phone

\_\_\_\_\_  
Address Line 2 Cell Phone

\_\_\_\_\_  
City, State, Zip Work Phone

\_\_\_\_\_  
Email Address \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Date of Birth

Preferred method of communication: \_\_\_\_\_ Nickname (if applicable): \_\_\_\_\_

### 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: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Volunteer Interest and Availability

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

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

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

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What are your hobbies, talents, and interests? \_\_\_\_\_

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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?    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 volunteered. Please note that we will only contact your references 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

## 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 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 a two-step Tuberculin skin test and to be in compliance with Evangelical Community Hospital's influenza vaccination and mandatory 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 a patient's privacy may result in my dismissal as a volunteer at Evangelical Community Hospital.

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Printed Name

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Signature

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Date

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

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Printed Name

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Signature

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Date

Please drop off, email, or mail your completed application to the Volunteer Services department:

Email: [volunteers@evanhospital.com](mailto:volunteers@evanhospital.com)

Mail: Evangelical Community Hospital, Attn: Volunteer Services, One Hospital Drive, Lewisburg PA 17837