KENTUCKY RIVER
MEDICAL CENTER

540 Jett Drive | Jackson, KY 41339 | 606-666-6000

VOLUNTEER SERVICES APPLICATION

PERSONAL INFORMATION

First: ________________________ Middle: _______________________ Last: ___________________________

Date of Birth: _________________________ Social Security #: _____________________________________

Driver's License #: ______________________ Photocopy: [ ] Yes [ ] No

Email: ____

Address: ____

City: _________________________________ State: __________________ Zip: _______________________

Phone: ______________________________ Secondary Phone: ______________________________________

Do you speak any foreign languages? [ ] No [ ] Yes If yes, please list: __________________________

____

EMERGENCY INFORMATION

Emergency Contact: ____

Relationship to You: _____________________________ Home Phone: ____________________________

Work Phone: __________________________________ Cell Phone: ______________________________

QUESTIONNAIRE

1. Why are you interested in volunteering? ____

____

____

2. Are you currently seeking volunteer experience to fulfill a community service obligation (i.e., church, school)? [ ] No [ ] Yes If yes, please describe the service requirements: ____________________

____

____

____

Service Organization & Contact: ____

Phone Number: ____

3. Is there anything that may adversely affect your ability to perform volunteer work? [ ] No [ ] Yes
   If yes, please describe in detail: ____
   ____
   ____
   ____

4. Are there any accommodations needed for you to perform volunteer work safely and completely as requested? ____
   ____
   ____
   ____

5. Do you have any physical, visual, or hearing needs we need to consider? [ ] No [ ] Yes
   If yes, please explain: ____
   ____
   ____
   ____

6. Are you physically able to transport patients? [ ] Yes [ ] No

7. Please check all areas that you are interested in working in the hospital:

[ ] Gift Shop
[ ] Accounting, Budget & Payroll
[ ] Admitting/Discharge
[ ] Cafeteria/Coffee Shop
[ ] Cardiac Cath Lab
[ ] Cardio-Pulmonary
[ ] Case Management/Patient Advocate
[ ] Clinical Laboratory
[ ] Communications
[ ] Dietary
[ ] Discharge Room
[ ] Education
[ ] Emergency Department Waiting Rooms or Registration only
[ ] Engineering
[ ] Greeters
[ ] Hospital Events
[ ] ICU Intensive Care Unit
[ ] Infection Control
[ ] Information Desk
[ ] Lobby Greeter
[ ] Mail Room
[ ] Materials Management
[ ] Medical Library
[ ] Medical Records
[ ] Oncology
[ ] Pastoral Care
[ ] Patient Floors
[ ] Psychiatry
[ ] Physician Lounge
[ ] Radiology
[ ] Rehabilitation Services
[ ] Recovery Room
[ ] Risk Management
[ ] Safety
[ ] Waiting Rooms/Visitor Areas
[ ] Other: ________________________________
____
____
____

EDUCATION & WORK EXPERIENCE

Education: Check highest level

High School: 9 [ ] 10 [ ] 11 [ ] 12 [ ] GED [ ]

Name & State: ____

If under 18, please list your primary interest of study/career goals: ______________________________

____

____

College: 1 [ ] 2 [ ] 3 [ ] 4 [ ] Graduate School: 1 [ ] 2 [ ] 3 [ ] 4 [ ]

Degree/Major: ____

Employment Experience:

Have you ever worked at a hospital? [ ] Yes [ ] No

Last Place of Work – if any: ____

Business Name: ____

Address: ____ Phone: __________________

Position: ______________________________ Supervisor's Name: __________________________

REFERENCES:

Please include references for any current or former job supervisors, teachers, or clergy.

Family members, relatives and friends may not provide recommendations.

Reference 1 Name: ______________________________________ Phone: __________________

Relationship to You: _______________________ Business Name: ___________________________

Address: __________________________ City: __________________ State: ____ Zip: _________

Reference 2 Name: ______________________________________ Phone: __________________

Relationship to You: _______________________ Business Name: ___________________________

Address: __________________________ City: __________________ State: ____ Zip: _________

OTHER

1. Have you ever been convicted of a felony? [ ] Yes [ ] No
2. Have you ever been convicted of a misdemeanor? [ ] Yes [ ] No

If "Yes" to either question, please describe the conviction(s) in detail, including dates.

____

____

____

3. How did you hear about this volunteer program? ____
____
____

4. Do you hold any special medical or clinical certifications or licenses, or had medical training of any type?
[ ] No [ ] Yes Please list: ____
____
____

5. When can you start volunteering? ____

6. Check when you wish to volunteer. Each shift is 4 hours.

[ ] Monday ________________________ to _____________________________
[ ] Tuesday ________________________ to _____________________________
[ ] Wednesday ________________________ to _____________________________
[ ] Thursday ________________________ to _____________________________
[ ] Friday ________________________ to _____________________________
[ ] Saturday ________________________ to _____________________________
[ ] Sunday ________________________ to _____________________________

CERTIFICATION AND AUTHORIZATION

I certify that the information I have provided is true and complete to the best of my knowledge. I understand that misrepresentation, falsification, or omission of information may disqualify me from further consideration for volunteering or may result in my termination as a volunteer.

If accepted as a volunteer, I understand that I must abide by all the policies, rules, and regulations of the Hospital.

I authorize the Hospital to investigate all statements contained in this application and to make inquiries of my personal references and medical history, as well as other related matters as may be necessary for determining my eligibility as a volunteer. I hereby release physicians, employers, schools, or individuals from all liability in responding to inquiries relating to my volunteer application.

Name: ____ Date: ______________________

CERTIFICATION AND AUTHORIZATION
FOR VOLUNTEERS

(Please read the following paragraph carefully before signing)

I certify that the information that I have provided is true and correct to the best of my knowledge and belief. I authorize Quorum Health Corporation (the "Company") to investigate my employment and personal history, including an inquiry concerning information on my criminal, credit and driving history, if appropriate. In connection with this investigation, I authorize all corporations, companies, credit agencies, educational institutions, persons, law enforcement agencies and former employees to release information they may have about me and release them from any liability or responsibility from doing so. This authorization, in original or copy form, shall be valid for this and any future investigation conducted by the Company. I am aware that if I am denied employment based on a report by a consumer-reporting agency, the Company will furnish the name and address of such agency upon my written request.

_______________ ____

Date Print legal first, middle, maiden, and last name

______________________________ __________________________________

Social Security Number DOB

____

Driver's License # & State Issued

____

Street Address

____

City, State, Zip

Please provide a copy of your Driver's License when applying for this position.

Also, please return to Kimberly Boggs, Marketing Director at 540 Jett Drive, Jackson, KY 41339.