



Physical Address:
5900 Byron Center Avenue, Wyoming, MI 49519
Phone 252-7029
Mailing Address: P.O. Box 916, Wyoming, MI 49509-0916

[Empty rectangular box for address or notes]

Last Name _____ First Name _____ M.I. _____

Street _____

City _____ State _____ Zip _____

Phones: _____ Email address _____

Are you at least 18 years of age? Yes No Are you eligible to work in the U.S.? Yes No

Education/ Training	High School _____ Graduate? <input type="checkbox"/> Yes <input type="checkbox"/> No - Highest Grade Attended _____
	College/Other _____ Number of years attended _____
	Degree(s) earned: <input type="checkbox"/> Assoc. <input type="checkbox"/> Bachelors <input type="checkbox"/> Masters <input type="checkbox"/> PhD Major: _____

Work Experience	Are you currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Retired from _____
	If yes, where? _____
	Days/times you work _____ Business Phone _____
	Does your employer have a volunteer giving program? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
	Previous Work Experience _____ _____

Volunteer Experience	_____
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Emergency Contact	Local person to be contacted in case of illness/emergency:
	Name _____
	Relationship to you _____ Phone _____
	Street Address _____
	City _____ State _____ Zip _____

References (Please list two adults over 21 yrs. who are not relatives and who have known you for at least two years.)	Name _____ Phone _____
	Street Address _____
	City _____ State _____ Zip _____
	Name _____ Phone _____
	Street Address _____
	City _____ State _____ Zip _____
If you have any friends/relatives employed or volunteering at Metro Health Hospital, please list their names:	

Volunteer Profile

Please give a brief summary of your background: _____

Reasons for wanting to volunteer _____
How did you learn about volunteer opportunities at Metro? _____
Is this a required volunteer assignment? _____ Yes No
If yes, number of hours needed _____ Deadline _____
Reason for the required hours: _____
Times and days available: _____

Skills:

- Computer
- Cash register
- Musical instrument _____
- Languages _____

Interests:

- Special Events
- Clinic Registration
- Hospital Tour Guide
- Short-Term Projects
- Phoning
- Nursing Care
- Vol. Trainer
- Newsletter
- Mailings
- Repairs
- Arts/Crafts
- Clerical Work

Other skills: _____ Other Interests: _____

Any particular volunteer activity/dept. you would like to try? _____

Any volunteer activity you would not want to be called upon to do? _____

Have you ever been convicted of a crime (other than a traffic violation) or misdemeanor? Yes No

If yes, please indicate the nature and date of occurrence.

COMMITMENT STATEMENT: *I affirm that the information I have supplied is complete and accurate to the best of my knowledge, and understand that falsification may prevent my placement or justify future dismissal. I also understand that a criminal background check will be conducted. I hereby request to become a member of the Volunteer Services Department at Metro Health Hospital and will abide by all hospital and department policies. I am willing to volunteer 50 unpaid hours of service within a one-year period (students will pledge at least one full semester or summer). I willingly agree to be trained and oriented, wear a volunteer uniform and ID badge, accurately record my service hours, get a yearly TB test, and comply with any other mandatory requirements. I will be responsible and regular in my attendance and will inform my department of necessary absences. Volunteering at Metro Health Hospital does not constitute an employment contract. My assignment can be terminated at any time with or without notice and for any reason. I will respect the need for safety, infection control, and patient confidentiality. I understand that my volunteer work experience will be recorded and held for future reference. I give my permission for release of this information.*

Signature _____

Date _____

PERMISSION FOR MINOR TO PARTICIPATE IN VOLUNTEER ACTIVITIES:

I permit my child to participate in volunteer activities at Metro Health Hospital and to receive a TB skin test, as required for Infection Control. I understand my child's services are donated without contemplation of compensation or future employment.

Parent/Guardian's Signature _____ Date _____



Criminal Record Check Consent Form

As a volunteer of Metro Health Hospital, I understand that it is Metro Health Hospital's policy to secure criminal history information as a condition of volunteering. If you feel the background check is inaccurate, you may appeal the results.

Name: _____
Last First Middle

Address: _____
Street City State Zipcode

Race: _____ Sex: _____ Birthdate: _____

Social Security Number: _____ Driver's License: _____

I understand the information above is required in order to obtain a conviction only criminal history file search and authorize Metro Health Hospital to utilize the information solely for this purpose. To the best of my knowledge, there are no disqualifying offenses on my record. However, if this statement is proven false, termination or criminal penalties may result. Additionally, I understand that I must contact the Volunteer Manager if any incidents occur that would affect my continued volunteer service with Metro Health Hospital.

Applicant Signature

Date



EQUAL OPPORTUNITY COMMISSION

PLEASE NOTE: COMPLETION OF THIS FORM IS VOLUNTARY

Metro Health considers all volunteer applicants for positions without regards to race, color, religion, sex, national origin, citizenship, age, mental or physical disability, veteran/reserve/National Guard, or any other similar protected status. We comply with all applicable laws governing employment practices and do not discriminate on the basis of unlawful criteria.

TO BE COMPLETED BY VOLUNTEER APPLICANT ON A VOLUNTARY BASIS AND NOT FOR INTERVIEW PURPOSES

****** FORM IS SEPARATE FROM APPLICATION ******

In an effort to comply with requirements regarding government record keeping, reporting and other legal obligations, which may apply, we request that you complete this applicant data survey. Providing this information is **STRICTLY VOLUNTARY**. Failure to provide the following information will not subject you to any adverse personnel decision or action. Your cooperation is appreciated.

APPLICANT INFORMATION

Date:

Volunteer Applicant's Name: _____
Last First Middle

Volunteer Position(s) Applied For: 1) _____
2) _____
3) _____

Gender: Male Female

Referral Source:

- Walk-in
- Website _____
- Advertisement located in: _____
- Private Agency
- Current Metro Employee
- Other _____

Please select one of the following Equal Employment Opportunity Identification Groups:

- Hispanic or Latino
- Asian
- American Indian/Alaskan Native
- Native Hawaiian or other Pacific Islander
- Caucasian (not of Hispanic origin)
- Black (not of Hispanic origin) or African American
- Two or more races

