Dear Prospective Volunteer,

Thank you for your interest in the volunteer program at Abilene Regional Medical Center. I am delighted you are interested in the possibility of becoming a part of ARMC.

Enclosed are the necessary papers to begin the process of you becoming a volunteer. Please complete the volunteer application then mail the paperwork back to me. Once I receive your application, I will contact you about the next upcoming orientation date. Orientation is held every other Monday from 8 a.m. to 2 p.m.

If you have any questions or concerns, please do not hesitate to give me a call.

Sincerely,
Valerie Petronella
Marketing Coordinator
Volunteer Services – Pet Therapy
Abilene Regional Medical Center
6250 Hwy 83/84
Abilene, TX 79606
(325)428-4953

YOU ARE THIS HOSPITAL

"You are what people see when they arrive here. Yours are the eyes they look into when they're frightened and lonely. Yours are the voices people hear when they ride the elevators, and when they try to sleep, and when they try to forget their problems. You're what they hear on their way to appointments which could affect their destinies. And what they hear after they leave those appointments. Yours are the comments people hear when you think they can't. Yours is the intelligence and caring that people hope they'll find here.

If you're noisy, so is the hospital. If you're rude, so is the hospital. If you're wonderful, so is the hospital. No visitors, no patients can ever know the real you, the you that you know is there – unless you let them see it. All they can know is what they see and hear and experience. And so we have a stake in your attitude, and in the collective attitudes of everyone who works at the hospital. We are judged by your performance. We are the care you give, the attention you pay, the courtesies you extend."

Thank you for all you're doing.

ABILENE REGIONAL Medical Center

VOLUNTEER SERVICES APPLICATION

PERSONAL INFORMATION

First _____ Middle _____ Last _____

Date of Birth _____ Social Security # _____

Driver's License # _____ Photo Copy [ ] 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 Name _____

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 _____

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

_____

_____

4. Is there anything that may adversely affect your ability to perform volunteer duties?

No [ ]Yes [ ] – **If yes, please describe in detail** _____

_____

_____

_____

5. Are there any accommodations needed in order for you to safely and competently perform volunteer duties? _____

_____

_____

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

[ ] Gift Shop
[ ] Information Desk / Lobby Greeter
[ ] Materials Management / Mail Room
[ ] Outpatient Pavilion
[ ] Pastoral Care
[ ] Pet Therapy *(Must be TDI Certified)*

7. When can you start volunteering? _____

_____

8. Check the date and enter the shift time when you wish to volunteer.

Each shift is 4 hours – typically either 8 a.m. to 12 p.m. or 12 p.m. to 4 p.m.

(Shift time does not apply to Pet Therapy volunteers.)

[ ] Monday _____ to _____

[ ] Tuesday _____ to _____

[ ] Wednesday _____ to _____

[ ] Thursday _____ to _____

[ ] Friday _____ to _____

[ ] Saturday or Sunday *(Pet Therapy only)* _____ to _____

EDUCATION & WORK EXPERIENCE

Education: Check highest level

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

Name & State of High School _____

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: _____

Business Name: _____

Address_____Phone_____

Position _____Supervisor's Name: _____

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

_____

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 or entered a guilty/no contest to a felony?**
   Yes [ ] No [ ]

2. **Have you ever been convicted or entered a guilty/no contest to a misdemeanor?**
   Yes [ ] No [ ]

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

_____

_____

_____

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 of 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: _____

ABILENE REGIONAL Medical Center

Pursuant to the requirement of the Fair Credit Reporting Act, notice is given that a consumer report may be in connection with your application for employment.

If you are denied employment, either wholly or partly because of information obtained in a consumer report, a disclosure will be made to you of the name and address of the consumer reporting agency making such report. You will also receive a copy of your report and a statement of your consumer rights.

By signing below, you consent to the procurement of a consumer report in connection with you application for employment and/or continued employment.

Applicant's (printed) First Name _____

Applicant's Middle Name _____

Applicant's Last Name _____

Applicant's Other Names _____

Date of Birth:_____ Social Security Number: _____-_____-_____

Address:_____

Address 2: _____

City: _____ State:_____ Zip:_____

* *for consumer report purposes only*

Please list all cities, states, and counties lived in for the last seven years.

City	State	County

A consumer report consists of employment records, educational verification, licensure verification, driving history, previous address, and other public records to criminal charges. A credit report will not be requested unless it is deemed pertinent to the functions of the position of which you are applying.

APPLICANT'S SIGNATURE: _____ DATE: _____

Abilene Regional Medical Center is directly or indirectly owned by a partnership that proudly includes physician owners, including certain members of the hospital's medical staff.