



Sisters of Charity of Leavenworth Health System

VOLUNTEER APPLICATION

Please Print

Date: _____

Last Name: _____ First Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Social Security No.: _____ Birthday: Month _____ Day _____

Home Phone: _____ Business Phone: _____

Occupation: _____ Employer: _____

School: _____ Grade: _____

Email address: _____

What do you hope to receive from volunteering? _____

What volunteer work have you done? _____

Hobbies &/or interests: _____

Are you an RSVP volunteer (Retired Senior Volunteer)? _____

What motivated you to become a Holy Rosary Healthcare volunteer? _____

What is your expected length of service? ___Regular ___Temporary

Have you ever committed, been convicted of, pled guilty to, or pled nolo contendere to, a felony or a misdemeanor? NOTE: *Conviction of a crime is not necessarily grounds for disqualification.*

___No ___Yes

If yes, please explain: _____

(If more space is needed for any of the above questions, please attach a separate piece of paper to the application)

Work Preferences:

___ Patient Contact

___ Sitting

___ Walking

___ Standing

___ No Patient Contact

___ Pet Therapy

___ Baby Rocker

___ Combination

Preferred times & days to volunteer:

	Morning	Afternoon	Evening
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

Please indicate the activities you are interested in:

- Clerical (alphabetizing, filing, copy machine typing)
- Delivering items throughout the hospital
- Guest Services (front lobby or clinic)
- Extended Care
- Visiting with Extended Care residents
- Puzzles, board games, cards, etc. with Extended Care Residents
- Gift Shop
- Plant caretaker
- Hospice

IN CASE OF EMERGENCY	
1. Name: _____	Relationship: _____
Home phone: _____	Work phone: _____
TWO CHARACTER REFERENCES – NOT RELATIVES	
1. Name: _____	
Relationship: _____	
Home phone: _____	Work phone: _____
Mailing Address: _____	
City: _____	State: _____ Zip: _____
2. Name: _____	
Relationship: _____	
Home phone: _____	Work phone: _____
Mailing Address: _____	
City: _____	State: _____ Zip: _____

I agree to represent Holy Rosary Healthcare in a professional manner and adhere to confidentiality procedures, and all other hospital policies, at all times. I will attend orientation and at least one training session per year.

Signature: _____ **Date:** _____

Vol. Coordinator Signature: _____ **Date:** _____

Below - Volunteer Coordinator Use Only

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- Name Badge Volunteer Handbook Position Description Age Specific Info.
 - Age Specific Quiz Confidentiality Orientation Safety Quiz Drug Awareness
 - Other