

**Good Shepherd Medical Center Linden
Volunteer Application**

PERSONAL DATA

Name _____ Street Address _____
City _____ State _____ Zip _____ Home Phone _____
Employed By _____ Address _____
Work Phone _____ Social Security Number _____
e-mail address _____
Birthday: Month _____ Day _____ In case of emergency contact _____ Ph # _____

EXPERIENCE

Previous Work Experience _____

Are you currently volunteering at another hospital? _____ If so, where? _____
Have you ever worked or volunteered at Good Shepherd Medical Center? _____ If so, what were your reasons for quitting? _____

Foreign Language(s) Spoken _____
Special Education or training _____

Skills/Hobbies _____

Community Affiliations _____

VOLUNTEER ASSIGNMENTS PREFERENCE

Please share with us the reason you are applying to be a volunteer _____

Referred by _____

Personal references (please do not list relatives):

Name _____ Telephone _____

Address: _____ City _____ State _____ Zip Code _____

Name _____ Telephone _____

Address: _____ City _____ State _____ Zip Code _____

Availability for volunteering M T W T F S S

Prefer: Mornings Afternoons Evenings

It is our policy to consider all applications without discrimination based on race, color, age, sex, religion, disability, national origin or citizenship. After your application has been reviewed, your placement for volunteer service will be determined. Volunteers are expected to comply with the rules and regulations of the Hospital and Volunteer Services Department. The first 3 months of volunteering is considered a training and probationary period.

Date _____ Signature _____

Volunteer Services
GOOD SHEPHERD MEDICAL CENTER LINDEN
VOLUNTEER APPLICATION DISCLOSURE/RELEASE

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

If you are denied placement, either wholly or partly because of information contained 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 the report and a statement of your consumer rights.

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

Today's

Date: _____

Applicant's Signature:

Applicant's Name (print):

Applicant's Other Last Names:

Social Security Number:

Date of Birth:

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

GOOD SHEPHERD MEDICAL CENTER LINDEN
LINDEN, TEXAS

STATEMENT OF CONFIDENTIALITY

I acknowledge, understand and agree that in the performance of my duties as a volunteer of the Good Shepherd Medical Center Linden, I must hold both medical and non-medical patient specific information in STRICT CONFIDENCE. In addition, I will also hold any information pertinent to the business practices of Good Shepherd Medical Center Linden in STRICT CONFIDENCE.

I understand that a violation of this confidentiality statement may result in disciplinary action or immediate termination of my service, if found to be valid after thorough investigation.

Signature

Date