Castle Medical Center

ADULT VOLUNTEER APPLICATION

Today's date _____

Name _____
Last First Middle

Address _____

City _____ Zip _____

Home phone _____Cell _____E-mail _____

Birthdate _____Spouse's Name _____

Who should be contacted in case you become ill or injured while volunteering?

Name _____Relationship to you_____

Phone _____

Status (please circle one) Student Retired Employed Unemployed

Business/professional training _____

Any previous volunteer experience? _____ Where and what did you do?____

_____

Do you have transportation? _____ By whom were you referred? _____

What are your hobbies, skills, special interests or community affiliations (church, clubs, etc)?_____

_____

********Please list two (2) references (no relatives please) who may be contacted*******

1. _____
Name Phone Relationship to you

2. _____
Name Phone Relationship to you

(over)

Castle Medical Center

ADULT VOLUNTEER APPLICATION

VOLUNTEER PLEDGE

Believing that Castle Medical Center has a real need of my services, I agree to:

- ***volunteer for a minimum of six (6) months or as a summer volunteer – at least one four-hour shift a week and not more than 12 hours per week***
- ***conduct myself professionally***
- ***treat others with courtesy, consideration and dignity***
- ***uphold the traditions and standards of Castle Medical Center, interpreting them to the community at large.***

Signature **Date**

Please note days/hours you will be available on a regular basis:

Day(s)_____Shifts _____ 8am to noon

_____ Noon to 4 pm

_____ 4 to 8 pm

_____ Other

In which volunteer position(s) are you interested (Escort, Gift Gallery, etc.)?

Date you will be ready to begin _____