Date Received	
Date Interviewed	
FOR OFFICE USE ONLY	

Volunteer Application

Name	Birthdate
Home Address	Phone Number
City, State, Zip	Social Security #
Email	
Healthcare Provider	

Emergency Contact	
Name	Relationship and Phone Number
1.	
2.	

Work or Volunteer Experience
1.
2.
3.
4.

References		
Name	Address, City, State, Zip	Telephone Number
1.		
2.		
3.		

Volunteer Areas of Interest
1.
2.
3.

Do you have a record of founded child or dependent adult abuse or have you ever been convicted of a crime in this state or any other: ☐ Yes ☐ No

If yes, please specify: ______________________

Community Memorial Hospital
UnityPoint Health

Please Read

By signing below, I certify that the answers and information set out on this application are accurate and complete, to the best of my knowledge. I acknowledge that if any answer or information is not accurate, or complete, I may not be asked to provide volunteer services at Community Memorial Hospital.

1. I authorize Community Memorial Hospital to investigate all statements contained in this application for volunteer service, as well as my character and qualifications. I release Community Memorial Hospital from all liability for acts performed in good faith and without malice in connection with the investigation of my background and evaluation of my application.
2. I understand and agree that the relationship between myself and Community Memorial Hospital may be terminated at any time by either party.
3. I understand acceptance to volunteer in patient contact areas depends on Community Memorial Hospital ensuring that I have no health problems including communicable diseases which would prevent me from volunteering effectively and with complete safety for myself and Community Memorial Hospital patients, employees, and visitors. Accordingly, I agree that if my health changes, I will submit a new medical clearance form from my healthcare provider and that my acceptance to volunteer will depend upon approval of Community Memorial Hospital.
4. I agree not to report to duty when infected or ill due to a communicable illness. I agree to submit a Communicable Illness Reporting Form upon return to duty.
5. I understand that as a volunteer, I must conform to all Community Memorial Hospital rules and regulations including those in the orientation packet. I also understand that I will be required to wear a name tag.
6. I hereby give permission to Community Memorial Hospital to conduct an Iowa criminal history and dependent adult/child abuse registry check with the Division of Criminal Investigation.

Signature ______________________________ Date ______________

Please return completed for to Jenny Gade at Jennifer.gade@unitypoint.org