

Patient Experience
One Hospital Drive
Lewisburg, PA 17837
P: 570-522-2144



Volunteer Application

Date of Application: _____ / _____ / _____ **Gender:** M F Non-binary

Type of Volunteer: Adult College Student High School Student (must be 18 years or older)

Last Name First Name MI

Address Line 1 Home Phone

Address Line 2 Cell Phone

City, State, Zip Preferred Name/Nickname (if applicable)

Email Address _____ / _____ / _____
Date of Birth

NOTE: Please do not list an email address if it is not checked regularly. Email will be the primary form of communication.

Education and Work Experience

Level of Education: High School Associates Bachelors Graduate Doctorate Other

Name of school attending/attended Major (if applicable) Grad. Month/Year

Have you ever been employed by Evangelical Community Hospital? Yes No

If yes, when? _____ Department: _____ Job Title: _____

Are you currently employed? Yes No Retired

Current/Previous Employer Job Title

Have you ever volunteered or are you currently volunteering elsewhere? Yes No

If yes, where? _____ Describe experience: _____

Volunteer Interest and Availability

Why do you want to be a volunteer at Evangelical Community Hospital? _____

What skills do you have to bring as a volunteer? _____

What are your volunteer areas of interest at Evangelical? (patient-care area, customer service, clerical, etc.)

What are your hobbies, talents, and interests? _____

When would you be available to volunteer?

- Sunday Monday Tuesday Wednesday Thursday Friday Saturday
 Mornings Afternoons Evenings

Have you ever volunteered at Evangelical Community Hospital before? Yes No

If yes, when? _____ Area: _____ Reason for leaving: _____

Have you ever pled guilty or been convicted of a misdemeanor or felony? Yes No

If yes, when did the offense occur? _____ Nature of crime: _____

Are you required to volunteer? Yes No

If yes, by whom? _____ Describe requirements: _____

NOTE: We do not accept volunteers looking to serve court-ordered community service.

Are you willing to commit to at least 50 volunteer hours for a 6-month period? Yes No

How did you hear about our volunteer program? _____

If selected to be a volunteer, what size shirt would you need? _____

References

References should not be relatives or anyone who lives in your household. We prefer references to be from places of employment or places where you have previously worked or volunteered. Please note that we may contact your references only if you are selected as a volunteer.

Reference 1:

_____	_____
Full Name	Relationship to You
_____	_____
Mailing Address	Phone Number
_____	_____
City, State, Zip	Email Address

Reference 2:

_____	_____
Full Name	Relationship to You
_____	_____
Mailing Address	Phone Number
_____	_____
City, State, Zip	Email Address

In Case of Emergency

Please list up to two emergency contacts. **At least one contact must be within 30 minutes of the Hospital.**

Primary:

_____	_____
Full Name	Relationship to You
_____	_____
City and State	Home Phone
_____	_____
Work Phone	Cell Phone

Secondary:

_____	_____
Full Name	Relationship to You
_____	_____
City and State	Home Phone
_____	_____
Work Phone	Cell Phone

Volunteer Requirements

Upon submission of this application, I hereby certify that all statements are true and correct to the best of my knowledge and belief. I hereby authorize Evangelical Community Hospital to investigate all statements and references contained in this application. I understand that misrepresentation or omission of facts called for herein will be sufficient cause for cancellation of consideration for volunteering or dismissal from Evangelical Community Hospital's volunteer program if I have become a volunteer.

If accepted to volunteer, I agree to abide by the rules and policies of Evangelical Community Hospital. I understand that if selected to be a volunteer, I will be required to complete the new volunteer process and attend orientation before beginning to volunteer. In connection with my application for volunteering with Evangelical Community Hospital, I will complete required paperwork and I understand that investigative background inquiries will be done, including state police criminal record checks and child abuse clearances in compliance with the Pennsylvania Act 153.

I understand that as a new volunteer, I will be required to complete required health screenings and to be in compliance with Evangelical Community Hospital's vaccination and masking policies.

I acknowledge and understand that patient information is strictly confidential. All Hospital employees and volunteers have an obligation to maintain patient confidentiality. Information concerning patients must never be discussed by volunteers or shared with other people inside or outside Evangelical Community Hospital. I will not seek information regarding a patient. I understand that any violation of the Hospital's policies or failure to abide by the expectations may result in my dismissal as a volunteer at Evangelical Community Hospital.

Printed Name

Signature

Date

Please mail or email your completed application to the Patient Experience department:

Email: volunteers@evanhospital.com

Mail: Evangelical Community Hospital, Attn: Patient Experience, One Hospital Drive, Lewisburg PA 17837