PARKVIEW HEALTH

Volunteer Application

Please either mail, fax, or scan and e-mail your completed application to Volunteer Services.

Mail: ATTN: Volunteer Services
Parkview Regional Medical Center
11104 Parkview Circle, Suite 420
Fort Wayne, IN 46845

E-mail: volunteer@parkview.com

Fax: 260-266-1459

Personal Information

Last Name:_____ First Name:_____

Date of Birth (mm/dd/yyyy):_____ Gender: ❑Male ❑Female SSN: _____

Street Address: _____

City:_____ State:_____ ZIP Code:_____

Home Phone: (_____)_____ Cell Phone: (_____)_____

E-Mail Address: _____

Have you ever been employed by Parkview or an affiliate?

❑Yes ❑No If yes, please list dates: FROM:_____ TO:_____

Have you ever been a volunteer for Parkview or an affiliate?

❑Yes ❑No If yes, please list dates: FROM:_____ TO:_____

Parkview Locations: (Please check the Parkview locations in which you are interested)

❑Parkview Regional Medical Center ❑Parkview Hospital Randallia ❑Parkview DeKalb Hospital
❑Parkview Huntington Hospital ❑Parkview LaGrange Hospital ❑Parkview Noble Hospital
❑Parkview Wabash Hospital ❑Parkview Whitley Hospital

Education: (Please mark the box of your highest educational level)

❑GED ❑Associates Degree ❑Masters Degree
❑High School Diploma ❑Bachelors Degree ❑PhD

Please list school name, city and state: _____

Is this an obligated service of any kind (school, court mandated, etc.)? ❑Yes ❑No

Is your volunteer time a limited time of service (summer, semester, etc.)? ❑Yes ❑No

Do you agree to a mandatory TB test and a recommended annual flu shot? ❑Yes ❑No

References: Please list two NON-RELATIVE references we can contact.

Paper reference forms will be mailed through the postal service to ensure the listed reference is the only person who has access to the form. For the same reason, the references must be mailed back through the postal service. Providing an E-mail address for your references is highly recommended to expedite your application process.

Name: _____ E-mail: _____

Street Address:_____ City:_____ State:_____ ZIP:_____

Name: _____ E-mail: _____

Street Address:_____ City:_____ State:_____ ZIP:_____

Criminal Background History:

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

If yes, please list all convictions and dates below:

Conviction/Date:_____ County/State:_____

Conviction/Date:_____ County/State:_____

NOTE: Conviction means you were found guilty by a judge, jury, "no contest," or guilty plea in court. A conviction may have taken place even if you did not pay a fine or spend any time in jail or prison. A conviction will not automatically disqualify you from volunteer placement at Parkview Health.

Any misrepresentation will disqualify you from a volunteer position. If needed, please use an additional sheet of paper.

Persons to Notify in Case of Emergency

Name:_____ Relationship:_____

Street Address: _____

City:_____ State:_____ ZIP Code:_____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Work Phone: (_____)_____

Name:_____ Relationship:_____

Street Address: _____

City:_____ State:_____ ZIP Code:_____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Work Phone: (_____)_____

Please Read Carefully And Sign

I certify the information in this application (and any accompanying documents) is true. I understand falsification of any information in this application, discovered at any time before, during, or after I begin my position as a volunteer may lead to my termination.

I hereby authorize Parkview Health Volunteer Services to verify, obtain copies of records and gather any information pertaining to my submitting a volunteer application with Parkview Health Volunteer Services. My signature on this application authorizes Parkview Health Volunteer Services to request written verification as needed.

The receipt of this application does not imply that I will be offered a position as a volunteer. If accepted as a volunteer, I agree to comply with established rules, policies, procedures and Parkview Health Standards of Behavior. This includes but is not limited to those which relate to confidentiality, employment and universal precautions.

I understand my volunteer position with Parkview Health Volunteer Services means volunteering at Parkview's discretion; my volunteer position can be terminated at any time with or without cause, and with or without notice at the option of Parkview Volunteer Services or myself.

Name (printed): _____

Signature: _____ Date: _____

PARENTAL/GUARDIAN PERMISSION REQUIRED for volunteers under 18 years of age.

I, the undersigned parent or legal guardian of the child named above, do hereby give permission for this child to perform volunteer service with Parkview Health Volunteer Services.

Parent/Guardian Signature:_____ Date: _____

Our Policy: It is the policy of this organization to provide equal opportunities without regard to race, color, religion, national origin, gender, sexual orientation, expression of gender identity, age, or disability.

Thank you for completing this application form and for your interest in volunteering with us.