



VOLUNTEER APPLICATION

Name: _____ Date: _____

Home Address: _____ Phone: _____

Mailing Address (if different) _____ Email: _____

Occupation: _____ Business Phone: _____

Have you ever been employed by or volunteered at DECH? Yes____ NO____

If Yes, what department? _____

How did you hear about Volunteer Service at DECH? _____

Do you have limitations or health conditions which should be taken into consideration before determining a volunteer assignment? Yes____ No____

If yes, please explain: _____

Hobbies, skills, special interests? _____

What area of the hospital are you interested in volunteering? _____

Do you speak a foreign language? _____ If yes what? _____

If you speak a foreign language would you be willing to be called in an emergency?

Yes: _____ No: _____

Have you ever been convicted of a crime? ____ If yes, explain when, where and disposition of case: _____

If you are involved in a crime or a conviction after your application process it is your responsibility to notify the volunteer coordinator.

Days preferred for volunteer service (circle) Sun M T W TH F SAT

Hours available: Morning_____ Afternoon _____ Evening_____



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Emergency Contact:

Name: _____ Relationship _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Immunization Status: A record of current immunizations is required to participate in volunteer program. Other immunizations required are MMR, Varicella, and TB.

Documentation of immunizations is attached to this application: Yes _____ No _____

References: Please list two non-relatives as references, include at least one former employer or volunteer supervisor.

1. Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____ Email: _____

2. Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____ Email: _____

If I am injured while I am on volunteer duty at Down East Community Hospital, the hospital has my consent for treatment in the Emergency Room.

I understand that due to the sensitive nature of the services provided by DECH all information pertaining to patients is strictly confidential.

I agree that I will be available to volunteer within the hours I have stated. If I cannot be available for those hours I will notify the Volunteer Coordinator in advance.

I consent to have the references listed above contacted by phone or mail.

Date: _____ Applicant's Signature: _____



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Thank you for completing this application to become a volunteer at Down East Community Hospital. Your interest in the hospital is greatly appreciated!

Background Check Information

Name: _____
 First Middle Last Name (Please Print)

Applicant's Previous name(s): _____

Date of Birth: _____

State in which Driver's License issued: _____

Address: _____

How long have you been at current address? _____

If you lived outside of Maine within the past three years, please list previous City & State

For Office Use Only:

Date Entered: _____

Notes: _____

