CELEBRATING 100 YEARS

THE RICHLAND HOSPITAL
and Clinics

VOLUNTEER APPLICATION

CONTACT INFORMATION:

Name *(First, Middle Initial, Last)*_____

Address_____City_____State_____Zip_____

Phone_____Email_____

Parent/Guardian's information, required if you are under the age of 18:

Name_____Phone_____

REFERENCES:

Please give two personal and work related references (not relatives), whom we may contact about you:

Name_____Phone_____

Address_____City_____State_____Zip_____

Relationship to you_____

Name_____Phone_____

Address_____City_____State_____Zip_____

Relationship to you_____

ABOUT YOU:

Are you a student? ❑ Yes ❑ No School: _____

Are you employed? ❑ Yes ❑ No Occupation: _____

Please indicate your favorite skills or hobbies and/or any special training or experience you have (if any):

_____

_____

How did you find out about the need for volunteers at this hospital?

_____

Do you need volunteer hours for a specific program/purpose? ❑ Yes ❑ No

If Yes, how many hours?_____What is the deadline, if any?_____

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AVAILABILITY:

We ask that you make a commitment to volunteer on a regular basis if possible.

Check your availability:

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Mornings	❑	❑	❑	❑	❑	❑	❑
Afternoons	❑	❑	❑	❑	❑	❑	❑
Evenings	❑	❑	❑	❑	❑	❑	❑

Do you plan to volunteer year round? ❑ Yes ❑ No

If no, which months?

❑ Jan ❑ Feb ❑ Mar ❑ Apr ❑ May ❑ Jun ❑ Jul ❑ Aug ❑ Sep ❑ Oct ❑ Nov ❑ Dec

SIGNATURE:

The Richland Hospital and Clinics runs a background check on all volunteers. Volunteers shall be accepted at the complete discretion of the Volunteer Coordinator and/or Hospital Administration. There is no obligation upon The Richland Hospitaland Clinics to accept a particular individual as a volunteer.

It is understood and agreed upon that any misrepresentation by me on this application will be sufficient cause for cancellation of this application and/or separation from service as a volunteer. I give the organization the right to investigate all references and to secure additional information about me, if related to the volunteer position. I hereby release from liability the employer and its representatives for seeking such information and all other persons, corporations or organizations for furnishing such information.

Signature of Applicant _____ Date _____

Signature of Parent/Guardian if under 18 _____ Date _____

Thank you for taking the time to complete the application.

Please return this application to:

The Richland Hospital and Clinics
Attention: Volunteer Coordinator
333 East Second Street, Richland Center, WI 53581

Questions? Please call the Volunteer Coordinator at 608.647.6321 ext. 2203