St. Peter's Health

VOLUNTEER APPLICATION

Name: _____

Primary Address: _____

City, State, Zip: _____

How long at this address?_____

Previous Address:_____

In what other states have you lived?_____

E-mail Address:_____

Birthdate:_____ Telephone Number: _____

Special training or skills you have that would assist us in your placement:

_____

_____

Previous volunteer or work experience: _____

_____

_____

Area of interest: _____

Days of service preferred:_____

Hours preferred: _____

References:

Name:_____ Address:_____

City, State, Zip:_____ Telephone number: _____

Name:_____ Address:_____

City, State, Zip:_____ Telephone number: _____

Name:_____ Address:_____

City, State, Zip:_____ Telephone number: _____

In the event of an emergency, please contact:

Name:_____
Telephone Number:_____
Relationship:_____
Name:_____
Telephone Number:_____
Relationship:_____

Final decisions on volunteer placement are based on ability of volunteer to perform the duty, interest of volunteer in volunteering in that capacity, and scheduling.

By signing this application:

- I give permission for the Volunteer Department of St. Peter's Health to contact my references and conduct a criminal check.
- I verify that I have never been convicted of a felony.
- I verify that the information on this application is true.

_____ _____

Signature Date