

Adult Volunteer Application

Personal Information																																							
Last Name			First Name				MI																																
<input type="checkbox"/> Ms. <input type="checkbox"/> Mr.		Preferred Name		Cell Phone		Home Phone																																	
<input type="checkbox"/> Mrs.																																							
Current Address				Best way to contact you (ex. phone, email)																																			
City		State			Zip																																		
E-mail Address																																							
Education, Employment, and Volunteer Experience																																							
Current Employer (optional)				<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time		Phone Number																																	
May we contact you at work? <input type="checkbox"/> Yes <input type="checkbox"/> No																																							
Hobbies, Skills, or Special Interests																																							
Previous volunteer or paid employment experience																																							
Have you volunteered at Columbus Community Hospital in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what position?																																							
Volunteer Placement Preferences (check all interests)				Availability																																			
<input type="checkbox"/> Administration & Projects				Please check the boxes for the days and times you are most often available to volunteer. <table border="1" style="width:100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="width: 20%;"></th> <th style="width: 7.5%;">S</th> <th style="width: 7.5%;">M</th> <th style="width: 7.5%;">T</th> <th style="width: 7.5%;">W</th> <th style="width: 7.5%;">Th</th> <th style="width: 7.5%;">F</th> <th style="width: 7.5%;">Sa</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">Morning</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td style="text-align: center;">Afternoon</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td style="text-align: center;">Evening</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </tbody> </table>					S	M	T	W	Th	F	Sa	Morning								Afternoon								Evening							
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Morning																																							
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<input type="checkbox"/> Crafts/Sewing																																							
<input type="checkbox"/> Family Care Services																																							
<input type="checkbox"/> Hospice																																							
<input type="checkbox"/> Patient Care Services																																							
<input type="checkbox"/> The Gift Shop																																							
<input type="checkbox"/> Wayfinding & Delivery Services																																							
Other Information																																							
Have you ever been convicted of a misdemeanor or felony? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain.																																							

Signature _____

Date _____