Volunteer Application

Last Name: _____ First Name: _____ MI: _____

Address: _____
(Number & Street) (City) (State) (Zip)

Preferred phone: _____ e-mail: _____

Date of Birth: _____ Social Security Number: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Date of Application: _____ ❑ Adult Volunteer ❑ Junior Volunteer (under age 18)

Why are you interested in volunteering at Mad River Community Hospital?

Previous employment/volunteer experience:

Interests/special skills:

Check the boxes of the job positions, days and times that you prefer:

Volunteer Duties

❑ Patient Care Units
❑ Information Desk
❑ Staffing the Gift Shop
❑ Emergency Department
❑ Garden
❑ Clerical/Charts
❑ Clerical/Home Health
❑ Other: _____

Availability

	S	M	T	W	T	F	S
Morning							
Afternoon							
Evening							

Are you able to commit to a minimum of one 3 hour shift per week?

Are you able to volunteer for a minimum of 6 months?

How did you hear about our volunteer program?

Do you know any MRCH Volunteers? ❑ Yes ❑ No If yes, please list:_____

Note: Please include one letter of reference with your application.

Thank you for your interest in volunteering!

Please return your application by mail to: Christie Duray, Manager of Volunteer Services, Mad River Community Hospital, P.O. Box 1115, Arcata CA 95518.
Questions? Call Christie at (707) 822-7220, ext. 4133 or e-mail: volunteers@madriverhospital.com.

Mad River Community Hospital

Immunization History

Name: _____ Social Security Number: _____

All hospital volunteers are required to have pre-placement drug and alcohol screening, an MMR titer, and an intradermal (skin) test for tuberculosis (TB), which are provided by the hospital at no charge after acceptance into the program. An additional TB test will be required annually. If you are under 18 years of age, we must have parental consent. (See bottom of page).

Illness/Immunizations

Give dates of last booster, if applicable:

Measles/Mumps/Rubella _____

Polio _____

Tetanus _____

Chicken Pox _____

Hepatitis B _____

Do you have allergies? ❑ Yes ❑ No

Incomplete applications will not be accepted

For Applicants Under the Age of 18

Applicant's Name:

Applicant's Signature: _____ Date: _____

Name of Parent or Guardian: _____ Phone Number: _____

I authorize Mad River Community Hospital to perform the pre-placement intradermal TB test, an MMR titer, and drug and alcohol screening for my minor child _____ (name).

Parent's Signature: _____ Date: _____