

Name: \_\_\_\_\_  
LAST FIRST M.I. NICKNAME

Telephone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Cell phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

E-mail address: \_\_\_\_\_ @ \_\_\_\_\_ . \_\_\_\_\_

Address: \_\_\_\_\_  
STREET APT# CITY STATE ZIP CODE

Mailing Address: \_\_\_\_\_  
(if different from above) STREET or PO BOX # APT# CITY STATE ZIP CODE

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

- Are references available if requested?
- Are you able to volunteer a minimum of 200 service hours annually?
- Have you applied for employment at Piedmont Rockdale Hospital within the past two years?
- Are you currently seeking employment?
- Have you been convicted of any crime other than a minor traffic violation in the past five years?

**Previous Volunteer Experience (All information must be completed in full)**

Name & City of Organization	Duties	Dates	
		From	To

**Employment History**

Name & City of Organization	Duties	Dates	
		From	To

**Emergency Information**

Name	Address	Phone #	Relationship

**OUR PURPOSE, OUR PROMISE - To make a positive difference in every life we touch**

**APPLICANT'S CERTIFICATION AND AGREEMENT**

(Please read carefully)

I understand that if I am chosen to be a Volunteer, it will be my responsibility to:

- Complete an orientation program scheduled for new members and attend service area training in my specific service area before beginning service;
- Complete mandatory annual educational requirements;
- Provide proof of immunity to Measles, Mumps and Rubella; provide documentation of COVID-19 vaccination;
- Complete tuberculosis screening process (provided free to volunteers);
- Wear a Volunteer badge and assigned volunteer uniform when working at the Hospital;
- Fulfill my assignments and hour obligations because the Hospital staff and patients depend on me; and
- If I am unable to work my normally scheduled hours, I will contact my volunteer service area coordinator.

**Health Requirements**

- Volunteers must bring copies of their immunization records; or if records are not available, obtain blood test results from your physician indicating you are immunized

I understand and agree that:

- Piedmont Rockdale Hospital has my authorization to thoroughly investigate my work and personal history to include criminal investigations. I will hold no person liable for giving or receiving information in this investigation.
- I have applied as a Volunteer at Piedmont Rockdale Hospital and hereby grant permission to release to the hospital any information requested concerning my work ability, character and employment or volunteer service. Prompt response to this request will be appreciated. A copy of my authorization bearing my correct signature has the same force and effect as the original.
- I understand that my personal insurance carrier will be the payee if I am injured while carrying out volunteer duties at Piedmont Rockdale Hospital.

I have read and agree to the above and hereby certify that the facts set forth in this application are true and complete to the best of my knowledge.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_