

BRISTOL HEALTH ADULT VOLUNTEER APPLICATION

Last Name _____ First Name _____ Middle _____

Address _____ Apt. # _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell _____ E-Mail _____ Date of Birth _____

EMERGENCY CONTACT: _____ Relationship: _____

Home Phone _____ Cell _____ E-Mail _____

EDUCATION/TRADE: _____

Field of Study _____ License(s)/Certificate(s) _____

VETERAN STATUS & BRANCH OF SERVICE:

Army- Navy- Air Force- Marines- Coast Guard- National Guard (circle all that apply)

Combat Veteran ? War Time Conflict?:

Other Volunteer Experience _____

Position(s) Held _____ Contact Name _____

Duties _____

REFERENCE #1 INFORMATION:

Reference (non relative) _____ Relationship _____

Email _____ Years Known _____

Home/Cell phone _____

REFERENCE #2 INFORMATION:

Reference (non relative) _____ Relationship _____

Email _____ Years Known _____

Home/Cell phone _____

EMPLOYMENT:

Employer _____ Years Employed _____

Position _____ Responsibilities _____

INTERESTS:

Please indicate the specific role or interests for which you are applying.

Department _____ Position _____

Department _____ Position _____

How Did You Hear About Our Program? _____

Hours You Are Available: M _____ T _____ W _____ TH _____ F _____ S _____ SU _____

Special Interests/Hobbies/Talents _____

Languages _____ Computer Skills _____

ASL _____

What Do You Hope to Accomplish Through Volunteering?

_____**IF ACCEPTED AS A VOLUNTEER AT BRISTOL HEALTH, I AGREE THAT:**

1. I will hold confidential all information that I may obtain directly or indirectly concerning patients or personnel.
2. Under no condition will I provide medical assistance or advice to a patient, visitor or staff member.
3. I will notify my Volunteer Ambassador, mentor or the volunteer office if I am unable to work as scheduled.
4. I will not sell goods or services, request contributions, or distribute political materials while on hospital premises.
5. My services are donated to the hospital without contemplation of compensation or future employment.
6. I agree to abide by the policies of Bristol Health and Volunteer Services.

If accepted into the Volunteer Program I understand that:

1. My signature below authorizes Bristol Health to initiate a **background check** via **HireRight**, our third party vendor.
2. I will need to complete **medical health screening** via Bristol Health Medworks or my PCP. This screening will include a review of my immunization and vaccine status, PPD/TB screening and seasonal flu vaccines, Covid 19 vaccination plus booster as applicable.
3. **Fingerprint screening** is required to serve as a Hospice volunteer or Ingraham Manor volunteer.

I have read each of the above conditions and I agree to honor them.

Signature_____
Date