Please return to: Metro Health Hospital
Volunteer Services Department
5900 Byron Center Avenue
Wyoming, MI 49519
Phone: (616) 252-7009
Fax: (616) 252-0120

Volunteer Application

Name: ____
(Last) (First) (Middle Initial)

Present Address: ____
(Street) (City) (State) (ZIP)

Permanent Address: ____
(Street) (City) (State) (ZIP)

Home Phone: (________) ______________________ Cell Phone: (________) ______________________

Email Address: ____

EDUCATION

Are you currently enrolled in a college or university program?

College: ______________________________ Circle last year completed: 1 2 3 4

Degree/Field of Study______________________________

High School: ______________________________ Circle last year completed: 9 10 11 12 GED

Other Training: ____

EMPLOYMENT & VOLUNTEER EXPERIENCE

Are you currently employed? □ Yes □ No

If yes, where? ____

Days/times you work ____

Previous Work Experience (list company names and dates) ______________________________

____

Have you ever been employed or volunteered at any of our locations? □ Yes □ No

If yes, where? ____

List any relatives or friends employed or volunteering at Metro Health Hospital

____

EMERGENCY CONTACT

Person to be contacted in case of illness/emergency:

Name ____

Relationship ______________________ Phone ______________________

REFERENCES

Please list two individuals over 18 yrs. who are not relatives.

Name ______________________ Phone ______________________

Street Address ____

City ______________________ State ______________ Zip ______________

Email ____

Name ______________________ Phone ______________________

Street Address ____

City ______________________ State ______________ Zip ______________

Email ____

LEVEL OF COMMITMENT

Some of our volunteer opportunities require a higher level of commitment while others are able to accommodate short-term availability (at least 50 hours). Please help us understand your level of commitment so that we may determine an appropriate volunteer opportunity.

What level of commitment do you feel most comfortable making at this time? Please check a box or specify below.

□ Less than 3 months □ 3 months □ 6 months □ 1 year

Is this a required volunteer assignment? □ Yes □ No If yes, number of hours needed: ____________________

Reason for required hours: ____

AVAILABILITY

Mornings: □ Yes □ No
□ Mon □ Tues □ Wed □ Thur □ Fri □ Sat □ Sun

Afternoons: □ Yes □ No
□ Mon □ Tues □ Wed □ Thur □ Fri □ Sat □ Sun

Evenings: □ Yes □ No
□ Mon □ Tues □ Wed □ Thur □ Fri □ Sat □ Sun

INTERESTS & SKILLS

□ Clerical (answering phones/computer work)
□ Coffee Shop
□ Child Life
□ Customer Service
□ Data Entry
□ Filing
□ Finance
□ Gardening
□ Gift Shop
□ Greeting Visitors
□ Hospitality Services
□ Languages: ____________________
□ Mail Delivery
□ Maintenance
□ Music
□ Nursing Care
□ Pet Therapy
□ Registration
□ Shuttle Driver
□ Special Events
□ Visiting Patients

COMMITMENT STATEMENT: I affirm that the information I have supplied is complete and accurate to the best of my knowledge, and understand that falsification may prevent my placement or justify future dismissal. **I also understand that a criminal background check will be conducted.** I hereby request to become a member of the Volunteer Services Department at Metro Health Hospital and will abide by all hospital and department policies. I am willing to volunteer 50 unpaid hours of service within a one-year period (students will pledge at least one full semester or summer). I willingly agree to be trained and oriented, wear a volunteer uniform and ID badge, accurately record my service hours, and comply with any other mandatory requirements. I will be responsible and regular in my attendance and will inform my department of necessary absences. I clearly understand that there is no employer/employee relationship and as a service volunteer I will not be entitled to compensation/workmen's compensation or fringe benefits of any kind for voluntary service. My assignment can be terminated at any time with or without notice and for any reason. I will respect the need for safety, infection prevention, and patient confidentiality. I understand that my volunteer work experience will be recorded and held for future reference. I give my permission for release of this information.

I voluntarily give consent and permission to Metro Health to take and use images (photographs and videotape) of me, with or without my name, for any advertising, marketing, informational, fundraising, or promotional purpose of Metro Health. I waive any right to, or interest in, my images and to any benefits that Metro Health may obtain arising from the use of my images. I release Metro Health and its officers, directors, employees, and agents from any and all liability associated with the taking or use of my images. I understand that this authorization remains in effect during my employment with Metro Health unless I revoke it.

If I become a volunteer with Metro, I understand that I will have access to a variety of confidential or proprietary information during the course of my placement with Metro. Such information includes, but is not limited to, confidential information related to Metro's business, patients, employees, donors, vendors, and suppliers, among others. Confidential or proprietary information belongs to Metro. If placed, I may not disclose confidential or proprietary information to any third parties. Upon the separation of my placement with Metro, I will immediately return to Metro all documents and materials that are Metro's property or that contain any confidential or proprietary information.

Signature ____Date _____________________

PERMISSION FORM FOR MINOR TO PARTICIPATE IN VOLUNTEER ACTIVITIES:
I permit my child to participate in volunteer activities at Metro Health Hospital and to receive a TB skin test, as required for Infection Prevention. I understand my child's services are donated without contemplation of compensation or future employment.

Parent/Guardian's Signature ____ Date _____________________

Note: Filing an application does not ensure a volunteer placement will be made. Applicants will be chosen by the Volunteer Services Department on the basis of qualifications, availability, and in keeping with the interest of the Hospital. All applications are held for one year.

In keeping with federal, state and local laws, Metro Health policy forbids employees and associates to discriminate against anyone based on race, religion, height, weight, pregnancy, genetic information, color, gender, age, marital status national origin, sexual orientation, veteran status, disability or any other characteristic protected by law. We are committed to establishing and maintaining a workplace free of discrimination. We are fully committed to equal employment opportunity. We will not tolerate unlawful discrimination in the recruitment, hiring, termination, promotion, salary treatment or any other condition of employment or career development. Furthermore, we will not tolerate the use of discriminatory slurs, or other remarks, jokes or conduct, that in the judgment of Metro Health, encourage or permit an offensive or hostile work environment. Metro Health also provides reasonable accommodations to disabled employees and applicants as required by law.

Criminal Record Check Consent Form

As a potential volunteer of Metro Health Hospital, please understand that it is Metro Health Hospital's policy to secure criminal history information as a condition of volunteering. If you feel the background check is inaccurate, you may appeal the results.

Have you ever been convicted of or plead guilty or no contest to a crime including all misdemeanors or felonies?

□ Yes □ No

Do you currently have any felony charges pending against you? □ Yes □ No

If yes to either of the last two questions, explain. ______________________________

____

____

Name: ______________________________

Last First Middle

Other Names Used (*maiden name, AKA names, etc.*) ______________________________

____

Address: ______________________________

City: ____________________ State: ____________________ ZIP: ____________

Gender: □ Male □ Female Birthdate: ____________________ Race: ____________________

I understand the information above is required in order to obtain a conviction only criminal history file search and authorize Metro Health Hospital to utilize the information solely for this purpose. To the best of my knowledge, there are no disqualifying offenses on my record. However, if this statement is proven false, termination or criminal penalties may result. Additionally, I understand that I must contact the Volunteer Services Department if any incidents occur that would affect my continued volunteer service with Metro Health Hospital. I also understand that Metro Health Hospital reserves the right to conduct periodic criminal history searches during my volunteer service tenure.

Signature ______________________________ Date ____________________