MID COAST–PARKVIEW HEALTH
Volunteers

Mid Coast–Parkview Health

Application for Volunteer Service

An asterisk (*) indicates a required field.

Name & Address

First Name:	*
Last Name:	*
Middle Name:	
Address:	*
City:	*
State:	*
Zip:	*
Primary Phone:	*
Work Phone:	
Cell Phone:	
Email Address:	

Profile Information

Date of Birth:	* / /
Sex:	* ☐ Female ☐ Male
Volunteer Site:	* ☐ Mid Coast Hospital ☐ Mid Coast Hospital - Parkview Campus ☐ Mid Coast Senior Health Center
Willing to Work Disaster:	☐
Willing to Sub:	☐
Never Been Convicted: *Check the box if you have never been convicted for the violation of any law.*	☐

Availability

Please indicate the days and times you are available to volunteer.

	Sun.	Mon.	Tue.	Wed.	Thu.	Fri.	Sat.
From:							
To:							

Emergency Contact

First Name:	*
Last Name:	*
Primary Phone:	*
Work Phone:	
Cell Phone:	
Relationship:	* ☐ Co-Worker ☐ Friend/Neighbor ☐ Guidance Director or Counselor ☐ Parent/Guardian ☐ Relative ☐ Spouse

Personal Reference

First Name:	*
Last Name:	*
How Does this Person Know You?	*
Primary Phone:	*
Work Phone:	
Email Address:	

Confidentiality & Volunteer Agreement

I understand that any information that I have access to regarding patients, such as a patient's name, is confidential and must not be repeated to anyone inside or outside of this hospital. I also understand that disclosing patient information in any form can lead to my dismissal as a volunteer.

As a volunteer at Mid Coast–Parkview Health, an Annual Fire, Safety, and HIPAA Test is required.

In the event of injury while I am on volunteer duty at Mid Coast–Parkview Health, the hospital has my consent for me to receive treatment in the Emergency Department.

I understand that I must complete an Authorization for Release of Information form to facilitate a background check.

I understand that I must have a Health Assessment with Employee Health.

The information provided on my application is correct and complete to the best of my knowledge, and I understand that any false or misleading statements on my application may result in refusal of my volunteer service.

______________________________ ______________________________

Signature Date

Please return your completed application to Shannon Coray, Director of Volunteer Services, at Mid Coast Hospital, 123 Medical Center Drive, Brunswick.