Volunteer Services Department
200 E. State St.
Alliance, OH 44601
Phone: 330-596-7821
Fax: 330-596-7117

Volunteer Application
Adult/Student/Teen

ALLIANCE COMMUNITY HOSPITAL
Experience Health Caring

Please Check ☐ Non-Student ☐ College Student ☐ High School Student	Date Date of Birth(Month/Day)

APPLICANT

(Please Print) Last Name	First Name	MI	Have you lived out of state in the last 5 years?
Address			City / Zip Code
Phone (Area Code)	Cell Phone		E-Mail Address

IN CASE OF EMERGENCY, WHOM DO YOU WISH TO HAVE NOTIFIED?

Name	Relationship	Phone (Area Code)
Address		Work Phone

TEENS/STUDENTS

If Under 18, parent or legal guardian	Relationship	Phone (Area Code)
Address		Work Phone (Area Code)

EDUCATION

High School		Graduated	☐Yes ☐ No Grade 9 10 11 12
College/University	Major	Graduated	☐Yes ☐ No

Are you required to volunteer for class credit? ☐ Yes ☐ No If yes, how many hours?

I will commit to a minimum of fifty (50) hours of volunteer service within a twelve (12) month period.

☐ Yes ☐ No

Have you volunteered for this organization before? ☐ Yes ☐ No

PERSONAL REFERENCES
(Exclude relatives and others under 18 yrs. old)

1. Name		Phone:	
Address	City	State	Zip Code
2. Name		Phone:	
Address	City	State	Zip Code

PROFESSIONAL REFERENCES

Present Employer/Past Employment		Phone:	
Address	City	State	Zip Code
Description of Duties:			

GUIDANCE COUNSELOR (FOR SR. HIGH STUDENTS ONLY)

Guidance Counselor name	School		Phone (Area Code)
Address	City	Ohio	Zip Code

PLEASE CONTINUE ON BACK OF THE PAGE

Volunteer Training Form

Family Physician	Phone:
Limitation Related to Health:	
Available days to volunteer: Please Circle M T W Th F Sa S A.M. P.M.	
Have you ever been convicted of a crime other than a minor traffic violation? ☐ Yes ☐ No	
If yes, please explain:	
The information listed above is accurate and correct to the best of my knowledge.	
Applicant's Signature:	Date:

Your signature indicates your approval for us to contact your physician regarding your physical and emotional health and to check the references you provided. The organization is not obligated to provide a placement, nor are you obligated to accept the position. I understand that I am required to abide by all the rules and regulations of the Alliance Community Hospital and the Volunteer Services Department, including meeting the JHACO requirements of PPD testing.

Parent or Guardian's Signature if Applicant is under 18: Date:

Your signature indicates your approval for your child to participate in the Teen Volunteer Program, your acknowledgement that he or she is in good health, and your consent for us to contact your child's physician.

Opportunities for volunteers are provided without regard to religion, creed, race, national origin, age or sexual orientation.

For Office Use Only

Position:

Training Days Scheduled: M T W Th F Sa S A.M. P.M.

Volunteer that will do training:

Comments:

For Office Use Only
Service Area:
Start Date:
Day/s Time: