Madison Regional Health
323 SW 10th Street
Madison, SD 57042
Volunteer Application Form
Return this form to Administration

PLEASE PRINT

Volunteer Application Form
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Name: _____ ( ) Male ( ) Female

Address: _____

Phone: _____ Date of Birth: _____ (Year Optional)

Email address: _____

Driver's License #_____ Expiration date: _____

Current Employment: _____

Past Employment Experience: _____

Education (Highest Level Completed): _____Major/Degree/Training: _____

Hobbies/Skills/Languages/Interests: _____

Previous Volunteer Experience: _____

Community Affiliations: _____

Please list 2 people, not related to you, for references:

Name: _____Address:_____

Phone #: _____ How are you acquainted? _____

Name: _____ Address: _____

Phone #: _____ How are you acquainted? _____

Availability for Volunteer Assignment

MON___ TUES___ WED___ THUR___ FRI___ SAT___ SUN___

Times Available: _____

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Length of Commitment: Months: _____ Years: _____

Area of Volunteer Interest:

_____ Valet parking _____ Gift Shop Other:_____

I understand that if accepted as a volunteer:

I voluntarily offer my services with a clear understanding that there is no monetary compensation including tips or gifts.

I will endeavor to conduct myself with dignity, courtesy, and consideration of others, and endeavor to make my work professional in quality.

I understand my ethical responsibility to protect patients' privacy. Information regarding patients must not be released, disclosed, or discussed either inside or outside the hospital.

I will observe all hospital regulations and be prompt and responsible in my service.

I will, if requested, submit to examinations, appropriate laboratory tests, and/or immunizations that may be necessary as part of my volunteer services.

I understand that Madison Community Hospital may complete a criminal background check.

I understand that the CEO or Department Head of the respected department in which I will be volunteering services reserves the right to terminate my volunteer status for reasons which include, but are not limited to (a) failure to comply with Hospital policies, rules and regulations; (b) absences without prior notification; (c) unsatisfactory attitude, work or appearance; or (d) any other circumstances in which disciplinary action has been taken and specified response disregarded.

I certify that all information on this application is true and complete.

_____ _____
Applicant Signature **Date**

_____ _____
Parent/Guardian Signature (if under age 18) **Date**

Return Application to:
Madison Regional Health System
Attn: Administration
323 SW 10th Street
Madison, SD 57042

Revised: July 2017; 6/2019