MUSC Health
Medical University of South Carolina
Florence Medical Center

For Internal Use:
Adult _____ Youth _____
Certifications: _____
_____
Birth Date _____

CONFIDENTIAL
VOLUNTEER SERVICES APPLICATION

Please print the **application,** complete and mail it to Volunteer Services along with **a letter of recommendation on business letterhead** (guidelines listed below under references). A **minimum of 60 hours of service required to volunteer.**

Volunteer Services
MUSC Health Florence Medical Center
805 Pamplico Highway
Florence, SC 29505

PERSONAL INFORMATION

First _____ Middle _____ Last _____

At least 18 years old: Yes ___ No ___ Social Security # _____

Driver's License # _____ Photo Copy [ ] Yes [ ] No

Email _____ _____

Address _____

City _____ State _____ Zip _____

Phone _____ Secondary Phone _____

Do you speak any foreign languages? [ ] No [ ] Yes- If yes, please list. _____

_____ _____

EMERGENCY INFORMATION

Emergency Contact _____

Relationship to you _____ Home Phone _____

Work Phone _____ Cell Phone _____

QUESTIONNAIRE

1. Why are you interested in volunteering? _____

_____

_____

2. Are you currently seeking volunteer experience to fulfill a community service obligation (i.e. church, school)? No [ ] Yes [ ] – If yes, please describe the service requirements _____

_____

_____

Service Organization & Contact _____

Phone Number _____

3. Is there anything that may adversely affect your ability to perform volunteer work?

No [ ]Yes [ ] – **If yes, please describe in detail** _____

_____

_____

_____

4. Are there any accommodations needed in order for you to safely and competently perform volunteer work as requested? _____

_____

_____

5. Do you have any physical, visual or hearing needs we need to consider?

No [ ]Yes [ ] – **If yes, please explain:** _____

_____

_____

6. Are you physically able to transport patients? Yes [ ] No [ ]

7. Please check all areas that you are interested in working in the hospital:

[ ] Greeters
[ ] Admitting / Discharge
[ ] Cafeteria
[ ] Materials Management
[ ] Infection Control
[ ] Cardio-Pulmonary
[ ] Case Management
[ ] Communications
[ ] Discharge Helper
[ ] Education
[ ] Emergency Department Waiting Rooms or Registration only
[ ] Rehabilitation Services
[ ] Waiting Rooms/Visitor Areas
[ ] Other: _____
[ ] Hospital Events
[ ] Information Desk
[ ] Dietary
[ ] Mail Room
[ ] Medical Records
[ ] Pastoral Care
[ ] Radiology

EDUCATION & WORK EXPERIENCE

Education: Check highest level

High School: 9 [ ] 10 [ ] 11 [ ] 12 [ ] GED [ ]

Name & State _____

If under 18, please list your primary interest of study/career goals _____

_____

_____

College: 1 [ ] 2 [ ] 3 [ ] 4 [ ] Graduate School 1 [ ] 2 [ ] 3 [ ] 4 [ ]

Degree/Major _____

Employment Experience:

Have you ever worked at a hospital? Yes [ ] No [ ]

Last Place of Work – if any: _____

Business Name _____

Address _____Phone _____

Position _____Supervisor's Name: _____

REFERENCES:

Please include **references for any current or former job supervisors, teachers or clergy that are 18 years old or older. Family members, relatives and friends may NOT provide recommendations. References must be different from the person writing letter of recommendation on business letterhead.**

Reference 1 Name: _____Phone: _____

Relationship to you: _____Business Name: _____

Address: _____ City: _____State: ___ Zip: _____

Reference 2 Name: _____Phone: _____

Relationship to you: _____Business Name: _____

Address: _____ City: _____State: ___ Zip: _____

OTHER:

1. Have you ever been convicted of a felony? Yes [ ] No [ ]

2. Have you ever been convicted of a misdemeanor? Yes [ ] No [ ]
If 'Yes' to either question, please describe the conviction(s) in detail, including dates.

_____

_____

_____

3. How did you hear about this volunteer program? _____

_____

_____

4. Do you hold any special medical or clinical certifications or licenses, or had medical training of any type? No [ ] Yes [ ] – Please list: _____

_____

5. When can you start volunteering? _____

6. Check when you wish to volunteer. Each shift is 4 hours.

[ ] Monday _____to _____

[ ] Tuesday _____ to _____

[ ] Wednesday _____to _____

[ ] Thursday _____to _____

[ ] Friday _____ to _____

[ ] Saturday _____ to _____

[ ] Sunday _____ to _____

Certification and Authorization

I certify that the information I have provided is true and complete to the best of my knowledge. I understand that misrepresentation, falsification, or omission of information may disqualify me from further consideration for volunteering, or may result in my termination as a volunteer.

If accepted as a volunteer, I understand that I must abide by all of the policies, rules and regulations of the Hospital.

I authorize the Hospital to investigate all statements contained in this application and to make inquiries of my personal references and medical history, as well as other related matters as may be necessary for determining my eligibility as a volunteer. I hereby release physicians, employers, schools or individuals from all liability in responding to inquiries relating to my volunteer application.

Name: _____

Date: _____

Volunteer Services Office:
(843)674-2975
geigerki@musc.edu