



VOLUNTEER CHAPLAINCY APPLICATION

NAME: _____ BIRTHDAY (month/day only) _____

HOME MAILING ADDRESS: _____

HOME PHONE: _____ EMAIL: _____

CELL: _____

DENOMINATION AFFILIATION: _____

CURRENT PASTORAL POSITION: _____

HOW LONG: _____

CHURCH: _____

ADDRESS: _____ PHONE NO: _____

PLEASE SUBMIT A COPY OF ORDINATION CERTIFICATE OR A LETTER OF ENDORSEMENT TO VERIFY ORDINATION FROM YOUR CHURCH / DENOMINATION WITH THIS APPLICATION. PLEASE PROVIDE A LETTER OF RECOMMENDATION ON BUSINESS LETTERHEAD THAT IS DIFFERENT THAN APPLICATION REFERENCES.

EDUCATIONAL RESUME: LIST DEGREES RECEIVED

YEAR

OTHER CREDENTIALS, ACHIEVEMENTS, LICENSE:

PERSONAL REFERENCES: (2 REQUIRED)

1.

NAME: _____

PHONE: _____

ADDRESS: _____

2.

NAME: _____

PHONE: _____

ADDRESS: _____

PLEASE LIST HOSPITALS OR HEALTHCARE PROVIDERS WHERE YOU HAVE SERVED AS CHAPLAIN WHICH MAY BE USED AS A REFERENCE:

HOSPITAL	ADDRESS	DATES OF SERVICES		PHONE
_____	_____	_____	_____	
_____	_____	_____	_____	
_____	_____	_____	_____	
_____	_____	_____	_____	
_____	_____	_____	_____	
_____	_____	_____	_____	

PLEASE STATE YOUR UNDERSTANDING OF THE ROLE OF A HOSPITAL CHAPLAIN:

PLEASE RETURN THIS COMPLETED FORM TO:
VOLUNTEER SERVICES
MUSC Health Florence Medical Center
805 PAMPLICO HIGHWAY
FLORENCE, SC 29505
geigerki@musc.edu