



Marion Medical Center

<i>For Internal Use:</i>	
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.**

Sheree Meadows, Coordinator
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
meadowss@muscc.edu**