

**Personal Information**

Last name:	First:	Middle:	Date of Birth
Is additional information relative to change of name, use of an assumed name or nickname necessary to enable a check on your work record? Yes ( <input type="checkbox"/> ) No ( <input type="checkbox"/> ) If yes, please explain:			
Street address:		Home phone:	Cell:
City:		State:	Zip:
Email address:			

**Employment Information (Please list most recent employer)**

Employer name:	Phone:	Employment dates Start:      End:	Job duties and responsibilities
Address:			
Job title:			
Supervisor name and title:			
Can we contact for reference? ( <input type="checkbox"/> ) Yes ( <input type="checkbox"/> ) No			

Your interests: (  ) Patient Care (  ) Friendly Visitor (  ) Clerical Assignments (  ) Pet Therapy (  ) Discharge Concierge  
(  ) Patient to Patient Emotional Support (  ) Music

**Availability**

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning							
Afternoon							
Evening							

Please estimate the number of hours you would like to volunteer each week (3 hours minimum):

Why are you interested in volunteering at Vassar Brothers Medical Center and how did you hear about our program?

Please list any hobbies or skills:

### Emergency contact

Name:	Relationship:
Address:	
Home phone:	
Cell phone:	

### Character References

Please include the name and address of two people, not related to you, who would be willing to respond to a letter of reference.

Name:	Address:	
Phone:	Email:	Relationship:
Name:	Address:	
Phone:	Email:	Relationship:

Have you ever been convicted of a crime (other than a minor traffic violation) in a court of law? If yes, please explain details below. (A conviction record will not necessarily prohibit you from volunteering.)

### Confidentiality statement

It is the responsibility of Vassar Brothers Medical Center and all of its physicians, employees, and volunteers to protect the confidentiality of the medical records and privacy of all patients. The patient has a legal right to privacy concerning his/her medical record. It is the obligation of Vassar Brothers Medical Center to uphold that right. For this reason, no member of the hospital to whom medical records or patient information is available may in any way violate this confidentiality. You are expected to hold all information about patients and their families in strict confidence and not discuss patient information with other volunteers or with other persons outside of the hospital. Persons found to be in violation of this policy will be subject to sanctions.

I have read the above statement and agree to abide by it.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Photography / Videography Consent Form

I hereby permit and release to Vassar Brothers Medical Center and/or its affiliates the use of pictures taken for the purpose of recruitment and publicity of the VBMC Volunteer Program.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Statement of application

The above statements are true, and all information and reference given on this application may be investigated without liability of Vassar Brothers Medical Center. If accepted to participate in the program, I agree to abide by the policies of the Volunteer Department of Vassar Brothers Medical Center. I understand that if any of the statements in this application are found to be untrue, or I fail to comply with all stated requirements, I may be subject to immediate dismissal from the Vassar Brothers Medical Center Volunteer Program.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_