

Southeast Indiana Health Center Volunteer Application

Prospective Volunteers will receive consideration without discrimination because of race, creed, color, sex, age, national origin or disability.

Full Legal Name: _____ **Date of Birth:** _____
Social Security Number: _____ **Race:** _____
Full Mailing Address: _____
Contact Number: _____ **Email:** _____

Education/Training/Special Skills: _____

Areas of interest: Check all that apply.

- | | | |
|---|---------------------------------------|---|
| <input type="checkbox"/> Medical Provider | <input type="checkbox"/> Nursing | <input type="checkbox"/> Pharmacy (Medication Assistance Program) |
| <input type="checkbox"/> Clerical | <input type="checkbox"/> Housekeeping | <input type="checkbox"/> Maintenance |
| <input type="checkbox"/> Fund raising | <input type="checkbox"/> Greeter | <input type="checkbox"/> Shadow /Observation Only |
| <input type="checkbox"/> Other | | |

Availability? (what day and what hours or how often) _____

Have you ever been convicted of a violation of a law or ordinance other than a minor traffic accident?

YES **No** **If yes, please explain.**

Note: Any convictions will be reviewed individually to determine if the offence will have any bearing on the applicant's ability to volunteer.

Please Read and Sign.

I certify that the information provided is true. I understand that if I falsify any part of this application or supporting documents, my volunteer services will be terminated.

I hereby authorize SEIHC to verify, obtain records or gather information pertaining to my application and the pre-requisites of this volunteer position. I understand that if I require testing or screenings that this is at my expense. My signature does not imply that I have been offered a position as a volunteer. However, if accepted as a volunteer I agree to comply with SEIHC rules, policies and procedures. I understand I am volunteering my time, talent and services freely and without compensation.

I understand that volunteering at SEIHC is at SEIHC discretion: my volunteer services can be terminated at any time with or without cause, and with or without notice by SEIHC or myself.

Applicant's Signature: _____ **Date:** _____

Parental/Guardian Permission Required for volunteers under 18 years of age. I, the undersigned parent or legal guardian of the child named above, do hereby give permission for this child to volunteer with Southeast Indiana Health Center.

Parent/Guardian Signature: _____ **Date:** _____

Approved for as a volunteer for SEIHC. All paperwork received and in order.

SEIHC Representative's Signature: _____ **Date:** _____