VOLUNTEEN PROGRAM APPLICATION

Date _____

Name _____
(Last) (First) (Middle Initial)

Current Address

_____
(Street) (City) (State) (Zip)

Phone _____
SS#:_____

Cell Phone _____ Email address:_____

Birth date____/_____/_____ Age_____yrs. Grade Point Average: _____

Number of Unexcused Missed School Days: _____

Areas of Interest in Volunteer Service:

- ☐ Radiology
- ☐ Administration
- ☐ Nursing
- ☐ Surgery
- ☐ Rehab
- ☐ Physician Office
- ☐ All Areas of Healthcare
- ☐ Lab

Days of the week preferred: ___Monday ___Tuesday ___Wednesday ___Thursday ___Friday

Hours preferred: ___Morning 8a – 12n ___Afternoon 12n-4p

Please list previous volunteer experience, if any:

_____

_____

Character References: (Please list name, address, phone number)

1._____

2._____

Why are you interested in the healthcare field?

_____

_____

What are your career plans after graduation?

_____

_____

Health Information

Do you have any limitations related to health? _____
If so, are you under a physician's care? _____ Physician's name_____

____Counselor or teacher letter of recommendation

The following requirements will be provided at OCH upon acceptance into

Program:
____TB Skin test (proof of immunization if required)
____Drug Screen
____Orientation
____Confidentiality Statement signed

Please return Volunteen packet **by May 13** to:

CeCe Robinson
Ohio County Hospital
1211 Main Street
Hartford, KY 42347
270-298-5487
crobinson@ohiocountyhospital.com