

Volunteer Services Department
One Hospital Drive, Clarion, PA 16214
(814) 226-1670

Volunteer Enrollment Form

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zipcode: _____

Phone: _____

Birthdate: ____/____/____ Social Security #: _____

Emergency Contact: _____ Phone: _____

Email Address: _____ Country of Birth: _____

City and State of Birth: _____ Country of Citizenship: _____

Height: _____ Weight: _____ Gender: __F__M Race: _____ Hispanic: Yes/No

Hair color: _____ Eye Color: _____

I. **Skills & Interests**

Educational Background (If still in school, please specify which school and year.)

Current Occupation (If retired, please note your most recent occupation.)

Hobbies, Interest, Skills: _____

Volunteer Experience: _____

Why do you want to volunteer at Clarion Hospital? _____

Are you volunteering to fulfill school requirements? ___ yes ___ no

If yes, how many hours of service are you required to complete? _____

Is there a deadline by when you must complete your volunteer service? _____

II. **Availability**

For how long would you like to volunteer?

___ Indefinitely ___ During the summer
 ___ Until school requirements are met ___ Until you find a paying job

If there is any time of the year when you cannot volunteer, please specify which months.

(Example, you go to Florida from January through March.) _____

Keeping in mind that most volunteer positions require a commitment of only one or two half days per week, what times are most convenient for you?

___ weekday mornings ___ weekday afternoons ___ weekday evenings
 ___ weekends ___ flexible

Date you are available to start: _____

III. **References**

How did you hear about us?

___ Retired Senior Volunteer Program (RSVP) ___ Hospital volunteer
 ___ Hospital employee ___ Advertisement

Please list the names and phone numbers of two references other than relatives:

Name: _____ Phone: _____

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