



Leesburg Regional Medical Center, 600 East Dixie Avenue, Leesburg, FL 34748 (Phone 352-323-5060)
Please return completed application to the hospital or by fax to 352-323-5539.

VOLUNTEER SERVICES APPLICATION

PLEASE PRINT CLEARLY.

Date: _____

Last Name: _____ First Name: _____ Mid. Initial: _____

Phone: Home: _____ Cell: _____ Work: _____

Gender: [] Male [] Female Birth date: ____/____/____

Address: _____

City: _____ Zip: _____

Previous address (if less than six years at current address): _____

City: _____ State: _____ Zip: _____

[] Permanent resident [] Seasonal resident

(Seasonal residents) Other address: _____

SSN: _____ Driver's License #: _____

E-mail address: _____

Current Employer: _____

Address: _____

Phone: _____ Supervisor's name: _____

Job duties and responsibilities: _____

Spouse/partner name: _____ Phone if different: _____

How did you hear about the Alliance volunteer program? _____

Emergency Contact: (Other than spouse) Name: _____

Relationship: _____ Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

References (Local preferred, no relatives):

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Education

School/College Name	Location	Graduated?	Diploma/ Degree	Major/Minor Course work
High School		<input type="checkbox"/> Yes <input type="checkbox"/> No		
College		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Graduate School		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Other schools/special training:				

Languages spoken (other than English): _____

Occupation/Former Occupation: _____

Work Experience/Professional Skills: _____

Are you currently seeking employment at the Central Florida Health Alliance or any other company? Yes No
If yes, where? _____

What is your expected time commitment to the Auxiliary? 3-6 months One year or more

Recreation/Hobbies: _____

Volunteer Experience/Community Affiliations: _____

Why do you want to volunteer with the Alliance? _____

Service Preferences: **Time:** Morning Afternoon Evening

Day(s): Mon. Tues. Wed. Thurs. Fri. Sat. Sun.

Assignment: Please check your preferences: (Areas marked with * require primarily walking/standing.)

- * Ambassador (greet and escort patients)
- * Ambulatory Diagnostic (customer service for patients, clerical work, transport discharged patients)
- * Ambulatory Surgery (clerical work, run errands, transport discharged patients)
- Cardiovascular Intensive Care (liaison for visitors, maintain waiting room)
- Clergy Office (assist visiting clergy at Lobby Desk)
- Day Surgery Center (reception for patients, paperwork for staff, filing)
- * Emergency Department (patient liaison with staff, replace linens, stock supplies)
- Emergency Department Triage (assist with patient arrivals, liaison for visitors/patients)
- * Gift Shop (retail operation: operate cash register, assist customers)
- Health Information Services (sort and distribute reports)
- ICU Waiting Room (liaison for visitors, maintain waiting room)
- * Lobby Desk (greet patients/visitors, give directions/information, deliver flowers, discharge patients)
- North Campus Lobby (greeting/information for visitors)
- * Patient Floors (discharge patients, run errands, provide information for visitors, assist with clerical work)
- Surgical Waiting Room (reception/information/liaison with families)
- * Thrift Shop (retail operation: stock merchandise, assist customers)
- Transport (drive hospital golf carts to pick up/drop off visitors, patients, and staff to parking lots)

Have you previously been an employee/volunteer for either Leesburg Regional Hospital or The Villages Regional Hospital? Yes No

If yes, please provide dates or employment/volunteer service, location and name of supervisor:

Any relatives employed, or other volunteers serving, at the Alliance? Yes No

If yes, please list name(s) and department(s): _____

Have you been convicted of a felony or misdemeanor offense, including offenses where adjudication of guilt was withheld? (Not including minor traffic violations) _____ Yes _____ No

If yes, please explain: _____

Are there any charges currently pending against you other than traffic violations? ____ Yes ____ No

If yes, please explain:

I certify that all of the information provided by me on this application is true, correct and complete. I grant the Central Florida Health Alliance permission to verify this information in arriving at a volunteer decision. I understand that false or misleading statements or the omission of any information necessary to make this application complete will result in rejection of my application or dismissal from volunteer service.

Signature: _____ Date: _____

PLEASE READ AND SIGN.

If accepted as an Alliance volunteer, I agree to:

- Hold as absolutely confidential all information that I may obtain directly or indirectly concerning patients, staff and other volunteers.
- Donate my services without contemplation of compensation or future employment.
- Honor my commitment to a specific job assignment.
- Conduct myself with dignity, courtesy and consideration of others.
- Maintain a well-groomed appearance.
- Attend orientation and training as scheduled.
- Consent to annual performance evaluation.
- Carry out assignments in a professional manner and seek assistance when necessary.
- Discuss any problems, criticism or suggestions with my service area supervisor.
- Work a specified number of hours as assigned.
- Maintain a sign-in time sheet to be submitted to the Volunteer Services Coordinator monthly.
- Be punctual and notify my supervisor if unable to work as scheduled.
- Observe all present and subsequently issued Volunteer Services policies and procedures. I understand that the Alliance may revise its policies and procedures at any time.
- I understand that all Alliance facilities are tobacco/smoke free.
- I understand that a separate application is necessary if I wish to volunteer my time with the Auxiliary organization of either hospital.

I understand that the Volunteer Services Department of the Central Florida Health Alliance reserves the right to terminate my volunteer status as a result of 1) failure to comply with Alliance policies and procedures; 2) absences without prior notification; 3) unsatisfactory attitude, work or appearance; or 4) any other circumstances which, in the judgment of the Volunteer Services Coordinator, would make my continued service as a volunteer contrary to the best interests of the Alliance and its patients.

I consent to 1) any pre-volunteer testing/screening required by the Alliance; and 2) annual health testing and training required by the Alliance. I further give permission to the Alliance to investigate any and all information concerning my application in order to determine my qualifications. This includes but is not limited to: medical clearance, criminal background checks, employment and personal reference checks and educational verification.

I hereby certify that there are no misrepresentations concerning my personal and professional history. I am aware that misstatements of material facts may cause me to be disqualified from holding a volunteer position with the Alliance. I have read each of the above conditions and agree to honor all of them.

In the event of resignation or termination, I agree to return the Alliance identification badge issued to me.

Signature of applicant: _____ Date: _____

FOR OFFICE USE ONLY

Application received: _____ Interview Date: _____

Interviewed by: _____ Scheduled Orientation date: _____

Assignment: _____ Start date: _____

Comments: _____