



Volunteer Services  
 P.O. Box 1115, Arcata CA 95518  
 (707) 822-7220 x4133 phone | (707) 826-8207 fax  
 volunteers@madriverhospital.com

**Application for Volunteer Program**

Social Security Number: \_\_\_\_\_ Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_  
(Number & Street) (City) (State) (Zip)

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Previous employment/volunteer experience:

Please list any MRCH volunteers you know:

Three references from the community:

Name	Telephone
1. _____	_____
2. _____	_____
3. _____	_____

Special skills:

Educational background:

Interests & hobbies:

**Why are you interested in volunteering at Mad River Community Hospital?**

Please indicate your choice of job positions, days and times that you prefer. We will do the best we can to accommodate you.

- |  |   |
|--|---|
| <input type="checkbox"/> Patient Care/Med-Surg Floor | <input type="checkbox"/> Surgery Desk Liaison |
| <input type="checkbox"/> Information Desk            | <input type="checkbox"/> Charts/Clerical      |
| <input type="checkbox"/> Gift Shop                   | <input type="checkbox"/> Telephone            |
| <input type="checkbox"/> Other: _____                |   |

**Availability:**

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Afternoon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Evening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Mad River Community Hospital is a drug and alcohol-free work environment. A pre-placement screening will be conducted prior to volunteering.

To ensure patient safety and confidentiality, all volunteer candidates shall undergo a thorough background check by an independent investigation agency.

*Return application by mail to Kay Hofweber, Director of Volunteer Services, Mad River Community Hospital, P.O. Box 1115, Arcata CA 95518, or e-mail application to Kay at [volunteers@madriverhospital.com](mailto:volunteers@madriverhospital.com). If you have any questions, please call Kay at (707) 822-7220, ext. 4133.*



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**Confidential Health Survey**

Name: \_\_\_\_\_

Physician: \_\_\_\_\_

**Medical History**

Do you have any health considerations that would influence your participation in this program? If so, please explain:

- Do you have allergies?  Yes  No
- Do you have epilepsy?  Yes  No
- Do you have diabetes?  Yes  No
- Do you have back trouble?  Yes  No
- Have you ever had a positive chest x-ray for tuberculosis?  Yes  No

**Illness/Immunizations**

Give dates of last booster, if applicable:

- Measles/Mumps/Rubella \_\_\_\_\_
- Polio \_\_\_\_\_
- Tetanus \_\_\_\_\_
- Chicken Pox \_\_\_\_\_
- Hepatitis B \_\_\_\_\_

An intradermal (skin) TB test, a rubella titer, pre-placement drug screen, and alcohol screening are required and are provided by the hospital at no charge. The initial screening requires a two-step TB skin test, and an additional TB test will be required annually. If you are under 18 years of age, we must have parental consent.

**For Applicants Under the Age of 18:**

I authorize Mad River Community Hospital to perform the pre-placement intradermal TB test, a rubella titer, and drug and alcohol screening for my minor child \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Signature of Witness \_\_\_\_\_ Date \_\_\_\_\_