Newport Hospital
A Lifespan Partner

Volunteer Office
11 Friendship Street
Newport, RI 02840

VOLUNTEER APPLICATION

Date: _____ Name: _____

Telephone # ( ) _____E-mail Address:_____

Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact Person: Name: _____

Phone: _____ Relationship: _____

EDUCATION				
	Name & Location	Major	Dates Attended	Degree Obtained
High School				
College				
Other				

VOLUNTEER AND PAID EXPERIENCE				
Employer	Position	Duties	Dates	Reason for Leaving

SPECIAL SKILLS OR PROFESSIONAL MEMBERSHIPS/ORGANIZATIONS

Please give any other information you feel is pertinent to your application:

_____

_____

_____

OVER

REFERENCES (Please exclude relatives)

(1) Name: _____ Phone: _____

Address:_____ City _____ State _____ Zip _____

(2) Name: _____ Phone:_____

Address: _____ City _____ State: _____ Zip_____

Have you ever been convicted of a felony? Yes _____ No _____

If you cannot show proof of immunization for measles and German measles (MMR) and a recent PPD (tuberculosis) test, will you allow us to do the necessary tests at Hospital expense?

Yes ___ No _____

The above information is accurate and correct to the best of my knowledge. I agree to maintain Newport Hospital's policy of confidentiality in my volunteer work with patients, staff and visitors.

_____

(Applicant's Signature)

Opportunities for volunteers are provided without regard to religion, creed, race, national origin, age or sex.

DO NOT WRITE BELOW THIS LINE

Interviewed _____ by _____

(date)

Hospital Orientation _____

Placement _____ Days _____ Hours _____

Supervisor _____

Special Comments _____

_____

_____

_____

_____

LC/sjl 7/00