Gulf Coast Regional Medical Center

Volunteer Application

Name: _____ Date of Birth: _____

Address: _____

City: _____ ST: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

References: (Be sure to include any contacts you have here at the hospital)

Name: _____ Phone: _____

Name: _____ Phone: _____

In the event of an emergency, contact:

Name: _____ Phone: _____ Relationship: _____

Area of Interest:

☐ Greeter ☐ Waiting Room Attendant ☐ NICU Cuddle Program

☐ Discharge Attendant ☐ Clerical Support ☐ Chaplain

☐ Pet Therapy (S.P.O.T.)

Preferred days and hours:

Day (s): _____ ☐ Morning ☐ Mid Day ☐ Afternoon

How long do you intend to volunteer at GCRMC?

☐ Less than six months ☐ Six to twelve months ☐ One year or longer

Desired activity level:

☐ Very Active (capable of walking distances and pushing wheelchairs)

☐ Moderately Active (some walking)

☐ Limited Activity (requires mostly sitting)

Describe skills, interests or hobbies: _____

_____

Have you volunteered before? ☐ Yes ☐ No

If yes, what type and where?_____

_____

Reason for volunteering at GCRMC? _____

_____

_____

By my signature below, I understand that:

- I authorize an investigation of any and all statements contained in this application, for the purpose of determining volunteer decisions.
- I agree to abide by the rules and regulations of Gulf Coast Regional Medical Center and the Volunteer Services Department. I understand that my assignment at Gulf Coast Regional Medical Center will be in a volunteer capacity only.

Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

(If under age 18)