GRAND LAKE HEALTH SYSTEM

GRAND LAKE HEALTH SYSTEM VOLUNTEER APPLICATION

(Please print legibly)

Last Name _____ First Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip ____

Home Phone ( ) _____ Cell Phone ( ) _____

Email Address _____

Preferred way of contact: ☐ Home Phone ☐ Cell Phone ☐ Email ☐ Text Message

Person to be notified in an emergency:

Last Name _____ First Name _____ Relationship _____

Home Phone Number ( ) _____ Cell Phone Number ( ) _____

Education/Job Related Training History:

_____

_____

Work History:

Current/Last Employer _____ Occupation _____

Work Experiences:

_____

_____

Military Service:

☐ Active ☐ Retired

☐ Army ☐ Air Force ☐ Navy ☐ Marine Corps ☐ Coast Guard ☐ Reserves

How you served: _____

Have you volunteered with other organizations? If yes, where and when?

_____

_____

Do you have access to transportation? ☐ Yes ☐ No

Do you know a language other than English? ☐ Yes ☐ No

Language _____ ☐ Speak ☐ Read ☐ Write

How did you hear about Grand Lake Health Systems Volunteer Program?

- ☐ Newspaper
- ☐ Facebook / Grand Lake Health System Website
- ☐ Grand Lake Health System Employee
- ☐ Church Bulletin
- ☐ Health Fair
- ☐ Other _____

Area of Volunteering Interest:

- ☐ Grand Lake Hospice
- ☐ Joint Township District Memorial Hospital
- ☐ Community Outreach
- ☐ Other _____

Two Personal References: (not related to you):

Last Name _____ First Name _____

Address _____ City _____ State _____ Zip ____

Best Number to contact _____ Relation _____

Last Name _____ First Name _____

Address _____ City _____ State _____ Zip ____

Best Number to contact _____ Relation _____

By signing this application, I state that the information is true and correct to the best of my knowledge. If the Grand Lake Health System Volunteer Program requires additional information to process this application the potential volunteer will be contacted. If there are questions or concerns please discuss with the Volunteer Coordinator.

Signature _____ Date_____

Signature of Parent or Guardian if applicant is under 18 years of age _____

Return Application to:
Grand Lake Health System
Joint Township District Memorial Hospital
Attn: Volunteer Coordinator
200 St. Clair Street
St. Marys, Ohio 45885
Phone: 419-394-3335 ext. 2808