Volunteer Central Application

2520 E. Dupont Rd., Fort Wayne, IN 46825
(260) 416-3008

Thank you for your interest in volunteering at Dupont Hospital. Volunteers are accepted based upon their abilities, availability and our specific needs for people to provide service to our patients and support to those providing care for patients. All prospective volunteers or employees receive a routine background check which requires your SSN.

This application asks for the name and address of two people who can attest to your good character and suitability to be a volunteer.

Name:			Birthdate:		
Address:		City/State		Zip	
Alternate mailing address (if any):					
Home Phone:		Cell:		E-mail:	

For minors only:	Age:		School:		Grade:		Favorite Subject:	
Career Goal:			Activities/Interests:					
Is volunteering a school requirement?			Number of hours needed:			Teacher:		

Have you volunteered under a different name?		Yes		No	If "yes," explain why:
In case of Emergency notify:					
Name:		Telephone:		Relationship:	
List any relatives or friends working at Lutheran Hospital:					
Have you ever been convicted of a felony or misdemeanor?		Yes		No	
If yes, describe when, where and disposition of offense:					

Personal References: (Students: List one teacher and a second person)

Name:		Address:		City/State & Zip	
Occupation:				Years known:	
Name:		Address:		City/State & Zip	
Occupation:				Years known:	
Name:		Address:		City/State & Zip	
Occupation:				Years known:	

Schedule: Indicate days and times you are interested in volunteering:

	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.	Any Day	As Needed
AM									
PM									
Evening									

Special Job Skills or Interests

Job, Volunteer or Community Service Experience:

List below your present and past work/volunteer experience beginning with your most recent.

Company, Organization:				Company, Organization:			
Started		Left		Started		Left	
Reason(s) for Leaving:				Reason(s) for Leaving:			
Position(s) Held:				Position(s) Held:			
Job Duties:				Job Duties:			

Physical and Medical Background: (This information is not required)

Do you have any physical/mental problem which may limit your ability to perform the work of a volunteer?			No		Yes
Physician Name:		Phone Number:			

Education:

Did you complete 8th Grade?				Yes		No		
Indicate Number of years completed:	High School:		College:		Technical School:		Graduate School:	
Military Years of Service:			Branch of Service:					
Name of Last School Attended:								
Other Education Information:								

Certificate of Applicant:

The facts contained in this application for volunteer work are true and complete. I understand that if I become a volunteer, any false statements on this application will be cause for release from the program.

I authorize Lutheran Hospital to contact my current and/or former employers or work. I authorize such employers, the police department and other volunteer agencies to release my information to Lutheran Hospital regarding my qualifications, past work experience, work performance, employment status, character, behavior and any other information related to my work history and/or suitability for volunteering. I agree that all questions asked and information released in good faith shall be privileged, and I expressly release the Lutheran Hospital and any of its authorized representatives from any and all liability arising from questions asked, information released or statements made in good faith.

Agreement: I agree to adhere to the policies and procedures of Lutheran Hospital and Volunteer Central. I have no expectation of compensation and I am donating my time for personal reasons.

Signature: ____ Date: ______________________

If sending application electronically, type full name and date in this section to indicate agreement to above statement in the absence of a signature.		Date	

Medical Release

I hereby authorize Lutheran Hospital Associates to provide emergency care to me in the event of illness, accident or injury while I am volunteering at the Hospital.

Signature: ____ Date: ______________________

If applicant is a minor:

Parent Signature: ____ Date: ______________________

Lutheran Health Network
Parental Consent Form

Today's Date:____________________

Name of Parent (or Legal Guardians):____________________and_______________________

Address:_________________________City, State & Zip Code:_________________________

Child's Name:____________________________________Birth Date:___/___/___ Age:_____

Teen's Signature____

I (we) authorize administration of two free TB Mantaux test by Health Services. I (we) also give permission for a drug test to be completed by Health Services, on my son/daughter/charge for participation in this program. In addition, we give permission for the Lutheran Health Network Hospitals, at which our child volunteers/interns, to administer emergency treatment necessary while performing any volunteer/intern work.

Emergency Contact Information

____________________ Contact Name	____________________ Contact Telephone Number
____________________ Contact Address	____________________ Contact's Relationship
____________________ Physician's Name	____________________ Physician's Telephone Number

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Signature of Parent of Guardian Date

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Witness Date