

VOLUNTEER APPLICATION

the **TEAM**, the **TECHNOLOGY**

Please Print

Name (First, Middle Initial, Last) _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Home Phone (_____) _____ Work Phone (_____) _____

Cell Phone (_____) _____ Email _____

Employer _____ Occupation _____

Can receive calls at work: Yes No **Emergency Only**

Person to be notified in an emergency:

Name _____ Phone (_____) _____

Address _____ City _____ State _____ Zip _____

Education/Special Training _____

Work Experience _____

Two References (if you have volunteered elsewhere, please include a reference).

Name _____ Phone (_____) _____

Address _____ City _____ State _____ Zip _____

Name _____ Phone (_____) _____

Address _____ City _____ State _____ Zip _____

Check All Areas of Interest:

- | | | |
|---|---|--|
| <input type="checkbox"/> Blood Pressure Screening | <input type="checkbox"/> Cataract Surgery Transporter | <input type="checkbox"/> Dietary |
| <input type="checkbox"/> Floor Aides | <input type="checkbox"/> Gift Shop | <input type="checkbox"/> Greeters |
| <input type="checkbox"/> IMH Satellite Clinics | <input type="checkbox"/> Information Desk | <input type="checkbox"/> Iroquois Home Care |
| <input type="checkbox"/> Marketing/Volunteer Office | <input type="checkbox"/> Medical Imaging Transporter | <input type="checkbox"/> Medical Records |
| <input type="checkbox"/> OB | <input type="checkbox"/> Office Work | <input type="checkbox"/> Outpatient Rehabilitation |
| <input type="checkbox"/> Outpatient Surgery | <input type="checkbox"/> Pharmacy | <input type="checkbox"/> Resident Home |
| <input type="checkbox"/> Special Projects | <input type="checkbox"/> Surgery Center Receptionist | <input type="checkbox"/> Transporter |

Do you know a language other than English? Yes No

Language _____ Speak Read Write

Language _____ Speak Read Write

Other special skills: (computer skills, teacher, manicurist, hairdresser, masseuse, etc.)

Do you have access to transportation? Yes No

How did you hear about the IMH Volunteer Program? _____

Why do you want to be an IMH Volunteer? _____

What qualities (*skills, talents, knowledge, and experiences*) do you feel you can incorporate into your IMH Volunteer work? _____

Comments: _____

Applicant Signature

Date

Please mail or fax the completed application to:

Iroquois Memorial Hospital
200 Fairman Avenue
Fax: 815/432-7847

c/o Terri Fanning, Director Volunteers/Marketing
Watseka, IL 60970
Email: volunteers@iroquoismemorial.com