

Citizens Memorial Healthcare  
1500 North Oakland Ave  
Bolivar MO 65613  
Volunteer Application

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_  
(Last) (First) (Middle)

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Spouse's Name (if applicable): \_\_\_\_\_

List any physical limitations that would prohibit specific volunteer assignments: \_\_\_\_\_  
\_\_\_\_\_

Any special training: \_\_\_\_\_

Previous work experience as a volunteer: \_\_\_\_\_  
\_\_\_\_\_

Briefly state your reasons for entering volunteer services: \_\_\_\_\_  
\_\_\_\_\_

**Please let us know how you would like to volunteer:**

**Days preferred:**

Sunday  
 Monday  
 Tuesday  
 Wednesday  
 Thursday  
 Friday  
 Saturday

**Shift preferred:**

12-4  
 9-1  12-4  4-7  
 9-1  12-4  4-7  
 9-1  12-4  4-7  
 9-1  12-4  4-7  
 9-1  12-4  4-7  
 9-1  12-4  4-7

**Where would you like to work?:**

gift shop  
 information desk  
 host around hospital – POP cart  
 Long-Term Care Facility  
 Hospice  
 Cancer Care Center  
 Specific Department choice: \_\_\_\_\_  
\_\_\_\_\_

**Would you prefer to be a substitute only?**

**Please check your skills and hobbies below:**

<input type="checkbox"/> Arts	<input type="checkbox"/> Sewing	<input type="checkbox"/> Patient Contact (visiting)	<input type="checkbox"/> Accounting
<input type="checkbox"/> Clerical	<input type="checkbox"/> Story Telling	<input type="checkbox"/> Singing	<input type="checkbox"/> Gardening
<input type="checkbox"/> Computer	<input type="checkbox"/> Handicrafts	<input type="checkbox"/> Musical Instruments	<input type="checkbox"/> Typing
<input type="checkbox"/> Writing	<input type="checkbox"/> Public Speaking	<input type="checkbox"/> Filing	<input type="checkbox"/> Woodworking
<input type="checkbox"/> Outdoor skills	<input type="checkbox"/> Telephoning	<input type="checkbox"/> Knitting or Crocheting	<input type="checkbox"/> Other _____

**Please check which membership in the Auxiliary you desire:**

Active Membership (annual) - \$5.00  
 Associate Membership (annual) - \$10.00  
 Life Membership (exempt from further payment of dues) - \$100.00

**In case of emergency contact:**

Name: \_\_\_\_\_ Phone number: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

Citizens Memorial Healthcare does not discriminate in patient care services or in employment practices on the basis of race, sex, national origin, religion, age, physical or mental impairment, or veteran status.

I, \_\_\_\_\_, understand that I will have access to various times to personal and confidential information in the performance of my duties with Citizens Memorial Healthcare facilities. I understand that there are civil and legal penalties involved with the unauthorized divulgence or release of this written or oral information. I understand that I will not release, discuss, or otherwise divulge any information I receive while a volunteer or employee of Citizens Memorial Healthcare.

\_\_\_\_\_  
Signature

SS# \_\_\_\_\_

\_\_\_\_\_  
Date

Email \_\_\_\_\_