King's Daughters' Health
Volunteer Service Application

Date_____ Name _____ Home Phone (___)_____

Address _____ City/State/Zip _____

Occupation _____ Work Phone (___)_____

How did you hear about the volunteer program at King's Daughters' Health?

_____

Do you have friends/relatives who volunteer or are employed by King's Daughters'?

❑ Yes ❑ No If yes, name(s)_____

Have you been involved as a volunteer in any capacity? ❑ Yes ❑ No

If yes, when and where? _____

Education, training, talent and skills _____

Possible times for volunteering (state hours) (EXAMPLE: 8AM-12PM, 12PM-4PM, 4PM-8PM)

Sun_____ Mon_____ Tues_____ Wed_____ Thurs_____ Fri_____ Sat_____

Please list any physical limitations. _____

What do you hope to receive from your volunteer experience? _____

_____

List two personal references (Teen volunteers only need to provide one reference):

Name _____ Phone (___)_____

Name _____ Phone (___)_____

General Areas for volunteering (check areas of interest) ❑ Escorting patients ❑ Gift Shop ❑ Patient Visitor ❑ Magazine/Hostess Cart ❑ Information Desk ❑ Clerical Work

❑ Other _____

Have you ever been convicted of more than a minor traffic violation? ❑ Yes ❑ No

If yes, please explain. _____

VOLUNTEER RELEASE AUTHORIZATION:
I hereby authorize King's Daughters' to perform a criminal background check for any criminal information regarding me. I exempt King's Daughters' from my liability or damages resulting from the release of this information.

_____ _____
SIGNATURE DATE

TEEN INFORMATION ONLY (under 18 years of age)

School Now Attending:

_____ _____
GRADE

I hereby agree to allow my son/daughter to serve as a teenage volunteer for King's Daughters'. I fully understand that in the course of his/her duties she/he may be permitted to enter patient's areas of the hospital. I further release King's Daughters' from any responsibility or liability for any foreseen or unforeseen results of causes that may arise as a result of my son/daughter's service at King's Daughters'. In addition, I also realize the responsibilities of the organization and will cooperate with my son/daughter to comply with the rules and regulations.

Additionally, I agree that photographs and/or videotape may be taken of my child and used for public relations, marketing and/or advertising purposes of King's Daughters'. I waive all rights I and/ or my minor child may have for any claims for payment in connection with any exhibition, televising, showing or electronic display (including, but not limited to the World Wide Web) of said photographs, pictures or videotapes.

SIGNATURE:

_____ _____
PARENT OR LEGAL GUARDIAN DATE

Teens must be at least 16 years of age to volunteer.

Please fill out/return this application to:
King's Daughters' Health
1373 E SR 62
Madison, IN 47250