Marshfield Clinic
HEALTH SYSTEM

Volunteer Application

OFFICE USE ONLY
App Received: _____
Interview Date: _____
Volunteer No.:

APPLICANT INFORMATION:

NAME (LAST, FIRST, MIDDLE INITIAL):		DOB (00/00/0000):	
STREET ADDRESS:	CITY:	STATE:	ZIP:
EMAIL:		PRIMARY PHONE:	

EDUCATION:

SCHOOL:	DATE(S) ATTENDED:	DEGREE/DIPLOMA:

CURRENT EMPLOYMENT INFORMATION:

EMPLOYER:	OCCUPATION:	WORK PHONE:

SCHEDULE: ***(Fill in the days and times you are available.)***

	MON	TUES	WED	THUR	FRI	SAT	SUN
MORNING							
AFTERNOON							
EVENING							

EMERGENCY CONTACT INFORMATION:

NAME:	RELATIONSHIP:	PHONE:

By signing below, you agree that you will: (1) adhere to all Marshfield Clinic Health System (MCHS) Policies and Procedures, including but not limited to the MCHS governing confidentiality, infection control, and safety if MCHS selects you as a volunteer; (2) adhere to the attached Letter of Agreement if MCHS selects you as a volunteer; (3) grant MCHS permission to contact the above references and any other person or organization having any information related in any way to your fitness to be a MCHS volunteer; and (4) release from any and all liability and agree not to bring any claim or suit against, MCHS, its officers, directors, shareholders, affiliates, employees, insurers, agents, successors, and assigns, for collecting or disclosing the above-mentioned information or for any consequence related to such a collection or disclosure.

_____ _____

PRINT NAME DATE

_____

SIGNATURE (by signing this application, I acknowledge, in addition to the above, that I hold a valid driving license)