Community Memorial Hospital
PO Box 148, Sumner, IA 50674
Phone: 563-578-3275 Fax: 563-578-3279

Volunteer Application

Name:	
Street Address:	
City, State, Zip:	
Phone Number:	
Email Address:	
Emergency Contact:	
Phone Number:	
Healthcare Provider:	
Phone Number:	
Volunteer Experience:	

Do you have a record of founded child or dependent adult abuse or have you ever been convicted of a crime in this state or any other: _____Yes _____No
If yes, please specify: _____

By signing below, I certify that the answers and information set out on this application are accurate and complete, to the best of my knowledge. I acknowledge that if any answer or information is not accurate, or complete, I may not be asked to provide volunteer services at Community Memorial Hospital.

1. I authorize Community Memorial Hospital to investigate all statements contained in this application for volunteer service, as well as my character and qualifications. I release Community Memorial Hospital from all liability for acts performed in good faith and without malice in connection with the investigation of my background and evaluation of my application.
2. I understand and agree that the relationship between myself and Community Memorial Hospital may be terminated at any time by either party.
3. I understand acceptance to volunteer in patient contact areas depends on Community Memorial Hospital ensuring that I have no health problems including communicable diseases which would prevent me from volunteering effectively and with complete safety for myself and Community Memorial Hospital patients, employees, and visitors. Accordingly, I agree that if my health changes, I will submit a new medical clearance form from my healthcare provider and that my acceptance to volunteer will depend upon approval of Community Memorial Hospital.
4. I agree not to report to duty when infected or ill due to a communicable illness. I agree to submit a Communicable Illness Reporting Form upon return to duty.
5. I understand that as a volunteer, I must conform to all Community Memorial Hospital rules and regulations including those in the orientation packet. I also understand that I will be required to wear a name tag.
6. I hereby give permission to Community Memorial Hospital to conduct an Iowa criminal history and dependent adult/child abuse registry check with the Division of Criminal Investigation.

Volunteer Signature: _____ Date: _____

Please return this form to Crystal Lange, Credentialing Coordinator.