

# Adult Volunteer Application

## Personal Information

\_\_\_\_\_

(Last) (First) (Middle Initial)

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

Phone: \_\_\_\_\_ Email \_\_\_\_\_

Birthday Month/Day/Year \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### EDUCATION:

(Check all that apply) \_\_\_\_ High School \_\_\_\_ College \_\_\_\_ Post Graduate

Degrees \_\_\_\_\_

**WORK STATUS:** \_\_\_\_ Employed \_\_\_\_ Retired \_\_\_\_ Unemployed

If employed, current employer: \_\_\_\_\_ Phone \_\_\_\_\_

**SKILLS/WORK EXPERIENCE:** \_\_\_\_ Accounting \_\_\_\_ Leadership \_\_\_\_ Nursing \_\_\_\_ Computer

\_\_\_\_ Teaching \_\_\_\_ Public Speaking \_\_\_\_\_ Other- please specify

Are you interesting in supervising other volunteers? \_\_\_\_\_

### IN AN EMERGENCY, PLEASE NOTIFY:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

**HOW DID YOU HEAR ABOUT OUR PROGRAM:** \_\_\_\_ Friend \_\_\_\_ Newspaper \_\_\_\_ Brochure

\_\_\_\_ Bulletin Board \_\_\_\_ Web Site \_\_\_\_\_ Other (Please specify)

**VOLUNTEER AVAILABILITY:** Please indicate the days and times you are available:

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What is appealing to you about volunteering in a healthcare setting?

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**Service Area Opportunities:** (Please check any that would interest you)

Working with patients       Prefer no patient contact  
 In the community       Behind the scenes (Administrative/Clerical)  
 Reception/Waiting Room       Retail  
\_\_\_\_\_Special Interests (list)

**Have you ever committed, been convicted of, pled guilty to, or pled no lo contendre to a felony or a misdemeanor?** NOTE: (We do background checks, but conviction of a crime is not necessarily grounds for disqualification.)

No     Yes    If "Yes," please explain: \_\_\_\_\_

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**Have you ever worked/volunteered for Dignity Health (Catholic Healthcare West) or Mercy Medical Center Redding, St. Elizabeth Community Hospital, or Mercy Mt. Shasta Hospital?**

No     Yes    If "Yes," where and when: \_\_\_\_\_

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Completed applications can be mailed to:

**Mercy Medical Center Redding**  
**Attn: Volunteer Department**  
**2175 Rosaline Ave**  
**Redding Ca. 96001**

Or dropped off at the Main Hospital Lobby Information Desk – Monday – Friday 8 a.m. – 4 p.m.

For further information, please contact Gary Cassingham phone **530.225.6468** or e-mail [gary.cassingham@dignityhealth.org](mailto:gary.cassingham@dignityhealth.org) or Deanna Gunter phone **530.225.7550** or e-mail [deanna.gunter@dignityhealth.org](mailto:deanna.gunter@dignityhealth.org)

*The information provided in this application is true in all respects, without any willful omissions. I understand that if this application is false in any way, I will be dismissed without notice regardless of when the false information is discovered.*

### **AS A VOLUNTEER, I ...**

- Agree to complete the volunteer orientation and train until I am competent to perform the required duties.
- Agree to complete an ANNUAL education review, TB screening and Influenza Vaccination, as well as any additional service-specific training that may be deemed necessary.
- Agree to comply with all the rules and regulations of Mercy Medical Center Redding and to uphold the bylaws of its Volunteer Guild.
- Understand that I may be dismissed from my duties for willful wrongdoing or negligence and/or performing duties outside of my service guidelines.
- Agree to accept assignment to a new service area if absent for an extended period of time.
- Agree to call my Service Chairman as soon as possible when I have scheduling changes.

### **IMPORTANT NOTE**

As a Volunteer at MMCR, we ask you to serve at least 208 hours per year, which is 1 four-hour shift per week. Reporting to your assigned shift is important to the success of our Volunteer Program.

**CONFIDENTIALITY:** It is the belief of this hospital that all medical, financial, and personal information pertaining to a patient is confidential and is protected from unauthorized viewing, discussion, and disclosure. Therefore, Volunteers may look at, use, or disclose patient information ONLY as it relates to the performance of their duties. Any unauthorized viewing, discussion, or disclosure will provide grounds for immediate dismissal. Whenever it is questionable as to what information is confidential, it is your responsibility to discuss the matter with your supervisor before any breach of confidentiality occurs.

I acknowledge and have read the statements above and agree to abide by the expectations of Mercy Medical Center Redding and the Department of Volunteer Services.

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**Signature**

**Date**    /    /



**Dignity Health®**

Mercy Medical Center  
Redding