



## Application for Volunteer Service

Name: \_\_\_\_\_

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

\_\_\_\_\_

Telephone: \_\_\_\_\_ Alternative contact number: \_\_\_\_\_

Email address (Optional) \_\_\_\_\_

In case of emergency, who should we notify: \_\_\_\_\_

Relationship to applicant: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Have you ever volunteered your services before? Yes \_\_\_\_\_ No \_\_\_\_\_. If yes, where did you volunteer and what type of services did you provide?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you available to volunteer for service throughout the year? Yes \_\_\_\_\_ No \_\_\_\_\_  
If you are not available throughout the year, what months are you available?

\_\_\_\_\_  
\_\_\_\_\_

**What day(s) of the week are you available to volunteer: (please circle all that apply)**

Monday      Tuesday      Wednesday      Thursday      Friday      Saturday      Sunday

**What hours/shifts are you available to volunteer?**

6 a.m. – 10:00 a.m.      8:00 a.m. – 12:00      10:00 a.m. – 2 p.m.      12:00 – 4:00 p.m.

2:00 p.m. – 6:00 p.m.      4:00 – 8:00 p.m.      Gift shop: 9:00 a.m. – 1:00 p.m.  
1:00 p.m. – 4:00 p.m.

Other: \_\_\_\_\_

**What area(s) are you interested in volunteering your time? (Please check all that may apply)**

**For the Brunswick Campus**

Guest Services (Front Desk) \_\_\_\_\_ Emergency Room \_\_\_\_\_ Gift Shop \_\_\_\_\_  
Concierge Desk \_\_\_\_\_ Outpatient Surgery \_\_\_\_\_ Human Resources \_\_\_\_\_  
Health Information Center (library) \_\_\_\_\_ Cancer Care Center \_\_\_\_\_  
Special Fundraising Events (book sales, jewelry sales) \_\_\_\_\_  
Other: \_\_\_\_\_  
\_\_\_\_\_

**For the Camden Campus**

Guest Services (Emergency Room) \_\_\_\_\_ Guest Services (Surgery/Maternity) \_\_\_\_\_  
Guest Services (Imaging) \_\_\_\_\_ Clinical Area of Emergency Room \_\_\_\_\_  
Human Resources \_\_\_\_\_ Administration \_\_\_\_\_ Gift Shop \_\_\_\_\_  
Special Fundraising Events (book sales, jewelry sales) \_\_\_\_\_

**Please provide the names of two personal references:**

1. \_\_\_\_\_
2. \_\_\_\_\_

Please note: These individuals must complete the attached personal reference forms.

**I hereby apply to the Southeast Georgia Health System Auxiliary, and agree to comply with all its requirements and regulations. I further understand that any and all information regarding the treatment of patients is to remain absolutely CONFIDENTIAL.**

Applicant's signature: \_\_\_\_\_

Date: \_\_\_\_\_

Please mail completed application and personal references to:

**For the Brunswick Campus**  
Attn. Volunteer Services  
2415 Parkwood Drive  
Brunswick, GA 31520  
Phone: (912) 466-1071

**For the Camden Campus**  
Attn. Volunteer Services  
2000 Dan Proctor Drive  
St. Mary's, GA 31558  
Phone: (912) 576-6405

# Southeast Georgia Health System Volunteer Program

## Personal Reference Request Form

Name of Applicant: \_\_\_\_\_

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

City/State/Zip Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

I am submitting an application for membership to the Southeast Georgia Health System Volunteer Program. I cannot be considered for membership until my references have been checked and are on file. Please complete the information on the attached form and mail it at your earliest convenience to:

**For the Brunswick Campus**

Attn. Volunteer Services

2415 Parkwood Drive

Brunswick, GA 31520

Phone: (912) 466-1071

**For the Camden Campus**

Attn. Volunteer Services

2000 Dan Proctor Drive

St. Mary's, GA 31558

Phone: (912) 576-6405

Thank you.

Volunteer Applicant's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# Southeast Georgia Health System Volunteer Program

## Personal Reference Reply Form

Name of Applicant: \_\_\_\_\_

Name of Person Providing Reference: \_\_\_\_\_

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

City/State/Zip Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

	<b>Outstanding</b>	<b>Above Average</b>	<b>Average</b>	<b>Below Average</b>	<b>Unsatisfactory</b>
<b>Character</b>					
<b>Disposition</b>					
<b>Energy</b>					
<b>Enthusiasm</b>					
<b>Willingness to Assist Others</b>					
<b>Ability to Maintain Strict Confidentiality</b>					

Relationship to applicant: \_\_\_\_\_

How long have you known the applicant: \_\_\_\_\_

Additional comments regarding applicant (Use additional pages if necessary):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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Volunteer Applicant's Signature: \_\_\_\_\_

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	<b>Outstanding</b>	<b>Above Average</b>	<b>Average</b>	<b>Below Average</b>	<b>Unsatisfactory</b>
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Relationship to applicant: \_\_\_\_\_

How long have you known the applicant: \_\_\_\_\_

Additional comments regarding applicant (Use additional pages if necessary):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# CONFIDENTIALITY STATEMENT

As a Volunteer or Volunteer at the Southeast Georgia Health System, I do hereby certify that I will respect the confidentiality rights of every patient and guest. I understand that the confidentiality of information is strictly maintained to protect the privacy rights of the patient or guest. I pledge that I will not discuss or otherwise communicate any form of information concerning the care, condition or treatment of any patient.

I understand that failure to abide by the patient confidentiality requirements will result in my immediate termination from the Volunteer or VolunTeen Program.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_