



Story County Medical Center Volunteer Application

Date:

Name:

Address:

City:

Telephone:

Email address:

State:

Birthday:

Zip:

Age:

If you are under 18 years of age, please include your parent(s)/guardian information:

Parent(s)/guardian:

Home phone:

Work phone:

Please list past volunteer/work experiences, personality qualities, hobbies or interests that will help us place you in an area that will best fit your needs:

Why do you wish to become a volunteer at SCMC:

How did you hear about the volunteer opportunities at SCMC:

I am interested in volunteering in the following areas of the medical center:

- | | |
|--|---|
| <input type="checkbox"/> Long Term Care Activities | <input type="checkbox"/> <input type="checkbox"/> Long Term Care one on one visits |
| <input type="checkbox"/> Gift Shop | <input type="checkbox"/> <input type="checkbox"/> Human Resources |
| <input type="checkbox"/> Greeting station | <input type="checkbox"/> <input type="checkbox"/> Maintenance |
| <input type="checkbox"/> Landscaping/Lawn | <input type="checkbox"/> <input type="checkbox"/> Housekeeping |
| <input type="checkbox"/> Housekeeping | <input type="checkbox"/> <input type="checkbox"/> Dietary |
| <input type="checkbox"/> Acute Care Patient Visits | <input type="checkbox"/> <input type="checkbox"/> Special events (as needed basis) |
| <input type="checkbox"/> Filing, sorting, stuffing, etc. | <input type="checkbox"/> <input type="checkbox"/> I will work wherever you need me. |
| <input type="checkbox"/> Marketing Office | <input type="checkbox"/> <input type="checkbox"/> Other: |

Do you have any health restrictions or physical limitation that could affect your volunteer placement? Please explain:

I am available to volunteer:

- Once a week
- Once every other week
- Once a month
- On an as needed basis only
- Other:

The days I'm available are:

- Mondays Times:
- Tuesday Times:
- Wednesdays Times:
- Thursdays Times:
- Fridays Times:
- Saturdays Times:
- Sundays Times:

I know in advance that my schedule will change throughout the year: Yes No

I am willing to sign a confidentiality agreement regarding patient information: Yes No

I am willing to give requested information for a background check if requested: Yes No

Thank you for taking the time to complete the student volunteer application for SCMC. If you have any questions, feel free to call 515-382-7164. If not, please return the form:

Samantha Houston
shouston@scmcnevada.org
Fax 515-382-7164

Story County Medical Center
630 6th Street
Nevada, Iowa 50201