HealthAlliance Hospital
A Member of UMass Memorial Health Care

Application for Volunteer Services

Date of Application: _____

Personal Information

Name: _____
Last First Middle Initial
Address: _____
Number and Street City/Town State Zip Code
Telephone: (_____) _____Date of birth: _____
E-mail Address: _____Cell Number: _____
How did you hear about the Volunteer Program? _____

Emergency Contact Information

Name: _____Relationship:_____
Home Address: _____
Telephone: (_____) _____Cell Number: _____
Business Address: _____
Telephone Number: (_____) _____

Volunteer Information

Are you currently employed? _____ What is your position? _____
Have you ever been an Employee of HealthAlliance Hospital? _____
Or are you: retired: _____ homemaker: _____ student: _____ major: _____
Other: _____

What type of volunteer position are you interested in? Some areas are:

_____Office assistant/clerical
_____Patient Registration
_____Emergency Room (18 years and older)
_____Good Intentions by the Guild Gift Shop
_____Hospice (separate training)
_____American Cancer Society Resource Room (Fitchburg, Burbank Campus)
_____Stock Room
_____Information Desk
_____Patient Liaison
_____Simonds-Hurd Complementary Care Center (Fitchburg, Burbank Campus)
_____Cancer Center (Fitchburg, Burbank Campus)
_____Caring Hands Volunteer Program (Fitchburg, Burbank Campus)
_____Reiki Volunteer Program (Fitchburg, Burbank Campus)
_____Art in Medicine Program (Fitchburg, Burbank Campus)
_____Other_____

Volunteer Information

Do you have any unique hobbies or skills? _____
_____

Please describe the perfect volunteer assignment for you: _____
_____

What do you wish to gain from this volunteer experience? _____
_____

What is your availability? _____

Suggested shifts are Monday through Friday. 8:00 a.m. to 12:00 p.m. and 12:00 p.m. to 4:00 p.m. However, personal schedules are available for some positions.

	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
Morning							
Afternoon							

Signature of applicant: _____date:_____

PLEASE NOTE THAT ALL POTENTIAL VOLUNTEERS WILL HAVE A BACKGROUND CHECK AND DRUG SCREEN.

Professional References (non relative):
Name: _____Relationship:_____Telephone Number: _____
Address: _____

Name: _____Relationship:_____Telephone Number: _____
Address: _____

Volunteer Services
Hearts and hands together make a world of difference.

Please return this completed application to:
Volunteer Services/Heidi Getek
HealthAlliance Hospital
60 Hospital Road
Leominster, MA 01453

hgetek@healthalliance.com
978-466-2778

FOR VOLUNTEER OFFICE USE ONLY

Interviewed by: _____*Date:*_____
DATES: Medical Clearance: _____*CORI*_____
References Checked: _____
Department Placed: _____