

**SOUTH FULTON MEDICAL CENTER
AUXILIARY/VOLUNTEER APPLICATION**

Thank you for showing your interest in South Fulton Medical Center. A clear understanding of your background and work history will aid us in placing you in the position that best meets your qualifications. Your application process will be completed within 30 days.

GENERAL INFORMATION

Social Security # _____ Driver License #/State _____
Name _____ Home Phone _____
Address _____ Work/Cell Phone _____
City/State/Zip _____ Date of Birth _____
Previous Address _____
City/State/Zip _____

IN CASE OF EMERGENCY, PLEASE NOTIFY _____ Relationship _____
Address _____ Phone Number _____

EDUCATION

High School/GED ___ College 1year ___ 2 years ___ 3 years ___ 4years ___ Masters ___ Doctorate ___

EMPLOYMENT

Are you curently employed? ___ If yes, where? _____

CURRENT OR PREVIOUS EMPLOYER

Company Name _____
Address _____ City/State/Zip _____
Position Title _____ Supervisor Name _____
Dates of Employment _____

PREVIOUS VOLUNTEER EXPERIENCE

Organization Name _____

Address _____

City/State/Zip _____

Position Title _____

Supervisor Name _____

Dates of Employment _____

OTHER INFORMATION

Have you ever worked at South Fulton Medical Center? ____

If yes, please list dates of employment and department? _____

Do you have relative who currently work at South Fulton Medical Center? _____

If yes, please give us relative(s) name and department. _____

REFERENCES

Please list three references:

1. Name _____

Phone _____

Address _____

City/State/Zip _____

Relationship _____

2. Name _____

Phone _____

Address _____

City/State/Zip _____

Relationship _____

3. Name _____

Phone _____

Address _____

City/State/Zip _____

Relationship _____

PLEASE COMPLETE THE FOLLOWING STATEMENT

The reason I want to volunteer at South Fulton Medical Center is...

APPLICANT'S STATEMENT

I hereby certify that all answers given by me in this application are true to the best of my knowledge. I understand and agree to all information furnished in the application may be verified. I hereby authorize all individuals and organizations named or referred to in this application and any law enforcement organization to give all information relative to such verification and hereby release such individuals, organizations and South Fulton Medical Center from any and all liability for any claim or damage resulting therefrom.

Signature _____ Date _____

CONFIDENTIALITY STATEMENT

I understand and agree that in the performance of my duties as a South Fulton Medical Center Auxiliary Volunteer, I must hold all personal and medical information regarding South Fulton Medical Center patients confidential. Furthermore, I understand that intentional and involuntary disclosure

Signature _____ Date _____

Please provide us with a copy of your driver's license and social security card.
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AREAS OF INTEREST

Please place an "x" by the areas of interest

Fundraising

Gift Shop____ Merchandise Sales____

Patient Care Services

Emergency Department____ Rehabilitation____ Mother/Baby____

Patient Dietary____ Book Cart____ Chaplain Services____

Human Resources____ Leap Center____ Admissions____

Administration/Clerical____

Patient/Family Services

Outpatient Surgery____ Information Desk____

Please indicate times preferred (*please circle day and check time of day you prefer*)

Weekdays: M T W Th F Morning____ Afternoon____ Evening____

Weekend: Saturday Sunday Morning____ Afternoon____ Evening____

FOR INTERNAL USE ONLY

Assignment_____ Photo ID_____

Health Screen/PPD_____ Uniform: Yes____ No____

Orientation_____ Policies & Procedure _____

Schedule and Hours_____

Background Check_____ Copy of ____Social Security Card ____Driver's License