ST. LUKE'S®
Community
Medical Center
The Woodlands

St. Luke's Community Medical Center
Volunteer Services
17200 St. Luke's Way
Woodlands, Texas 77384-8007
936/266-4002
www.stlukeswoodlands.com

ADULT VOLUNTEER APPLICATION

NAME ____
(last) (first) (m.i.) (first name for badge)

Other name (if applicable) ______________________________

ADDRESS ______________________________ HOME PHONE ______________

CITY ____________________ ZIP __________ CELL PHONE ______________

SOCIAL SECURITY # ____________________ E-MAIL ______________________

EMPLOYMENT INFORMATION

CURRENT EMPLOYER (if applicable): ______________________________

ADDRESS ____

PHONE ______________ POSITION ______________ HOURS ______________

May we call you at work if necessary? ☐ Yes ☐ No

BUSINESS EXPERIENCE?

____

____

QUALIFICATIONS:

Level of Education: High School ________ College ________ Trade School ________ Graduate School ________

College Major ____

Name of current school ______________________________ Grade Point Average ________

Is volunteering a requirement for school credit? ______________ If so, how many hours? ________

Have you ever been convicted of or been on deferred adjudication for, ______________________

or are you now either awaiting trial for or on deferred adjudication for, ______________________

a felony or misdemeanor? ☐ Yes ☐ No ______________________

If yes, describe in full, including dates and locations. ______________________

Conviction will not necessarily bar volunteer service. ______________________

____

Prior volunteer experience?

____

____

Where did you hear about our program? ______________________________

____

____

____

____

Why do you want to volunteer at St. Luke’s Community Medical Center?

____

____

____

Would you be interested in helping the volunteer organization with extra projects such as fund raising and special events? ☐ Yes ☐ No

PERSONAL DATA:

(special skills, talents, hobbies, interests)

___ Accounting	___ Computer	___ Clerical	___ Music
___ Art	___ Microsoft Word	___ Answering Phones	___ Photography
___ Calligraphy	___ Microsoft Excel	___ Filing	___ Public Speaking
	___ Power Point	___ Desktop Publishing	___ Scrapbooks
		___ Event Planning	___ Writing

Languages: ______________________________

____

PLEASE LIST TWO LOCAL PERSONAL REFERENCES (other than family members):

Name ____________________ Phone ____________________

Address ____________________ City ____________________ Zip ____________________

Name ____________________ Phone ____________________

Address ____________________ City ____________________ Zip ____________________

Public Law 91-508 requires that we advise you that a routine inquiry may be made which will provide information concerning your character, reputation, personal characteristics, and mode of living. You may obtain a copy of this information upon written request.

I hereby certify that information I supplied in this application is true, complete and correct to the best of my knowledge and I understand that any information I withheld or falsely provided in connection with the foregoing application shall be cause for rejection of this application or termination of volunteer status. I hereby authorize St. Luke’s Community Medical Center, without liability, to contact prior employers (present employers if authorized), schools or references I have given and authorize said employers, schools or reference to make full response to any inquiries by St. Luke’s Community Medical Center in connection with this application for volunteer service, including police records.

I understand, and agree, that as a condition of my acceptance into the St. Lukes’ Volunteer Program, I will be required to pass scheduled physical examinations as they relate to my ability to discharge my duties. I HAVE READ, UNDERSTAND, AND AGREE TO THE FOREGOING PARAGRAPHS.

____
Volunteer Signature

IF ACCEPTED AS A ST. LUKE'S COMMUNITY MEDICAL CENTER VOLUNTEER, I AGREE THAT:

1. I shall hold as absolutely confidential all information that I may obtain directly or indirectly concerning patients, doctors or personnel, and not seek to obtain confidential information from a patient.
2. My services are donated to the hospital without contemplation of compensation or future employment, and given with humanitarian, religious or charitable reasons.
3. I understand that it is a crime to solicit business for attorneys. I shall not solicit any business for attorneys or insurance companies, both on or off of hospital property, or act as a runner or capper for an attorney in the solicitation of business. I shall report all known occurrences of solicitation for attorneys to the Supervisor-Volunteer Services.
4. I shall not sell or attempt to sell goods or services, request contributions, or solicit persons to sign or distribute political petitions on St. Luke's Community Medical Center premises.
5. I shall submit to examinations, which may include chest X-rays, skin tests, appropriate laboratory tests and/or immunizations, as part of my volunteer service. I hereby authorize my doctor(s) to furnish the hospital information concerning my health. I also authorize the person(s) making tests or X-ray films to report the results to the hospital.
6. I shall be punctual and conscientious, conduct myself with dignity, courtesy and consideration of others, and endeavor to make my work professional in quality.
7. I shall attempt to resolve any problems related to my volunteer activities with the Supervisor-Volunteer Services if unsuccessful, attempt to resolve any such problems with the Administrative Director responsible for Volunteer Services.
8. I shall make my best effort to fulfill my commitment to the hospital by completing all assignments that I accept.
9. I shall at all times uphold the mission of St. Luke's Community Medical Center.
10. I understand that the volunteer services department reserves the right to terminate my volunteer status as a result of
    (a) failure to comply with hospital policies, rules and regulations;
    (b) 3 absences without prior notification;
    (c) unsatisfactory attitude, work or appearance; or
    (d) any other circumstances which, in the judgment of the department management, would make my continued service as a volunteer contrary to the best interests of the hospital.

    I have read each of the above conditions and I agree to be bound by them.

____

Volunteer Signature Date

____

Volunteer Parent Signature Date
if Volunteer Under Age 18

WITNESS CLAUSE

I agree that I have explained each of the conditions of volunteer services to the applicant who has signed this form.

____

Volunteer Services Department Date
Representative Signature

INDICATE TIME AVAILABLE TO WORK:

	8:00 - Noon	**Noon - 4:00**	**4:00 - 8:00**
MONDAY			
TUESDAY			
WEDNESDAY			
THURSDAY			
FRIDAY			
SATURDAY			
SUNDAY			

BELOW FOR OFFICE USE ONLY:

	Date	By
1. Application received	____	____
2. Interview	____	____
3. Job description	____	____
4. Physical approved	____	____
5. Background cleared	____	____
6. Vol. file in computer	____	____
7. Orientation	____	____
8. Badge	____	____
9. Computer ID	____	____
10. Uniform	____	____
11. Department notified	____	____
12. File complete	____	____

Assignment: Day______________ Time______________

Start Date______________________________

Area______________________________

Comments______________________________

____

Assignment: Day______________ Time______________

Start Date______________________________

Area______________________________

Comments______________________________

____

Assignment: Day______________ Time______________

Start Date______________________________

Area______________________________

Comments______________________________

____

IN AN EMERGENCY NOTIFY:

Name____

Relationship______________________________ Phone (work)________________ (home)________________

Physician's Name____ Phone________________

Mailing Address____