GRAND LAKE HEALTH SYSTEM
VOLUNTEER APPLICATION

(Please print legibly)

Last Name ________________________________ First Name ____________________ Date of Birth _______

Address _____________________________________ City ______________________ State ______ Zip ____

Home Phone (   ) _________________________________ Cell Phone (   ) ____________________________

Email Address ____

Preferred way of contact: ☐ Home Phone ☐ Cell Phone ☐ Email ☐ Text Message

Person to be notified in an emergency:

Last Name ________________________________ First Name ___________________ Relationship _________

Home Phone Number (   ) _________________________ Cell Phone Number (   ) _______________________

Education/Job Related Training History:

____

____

Work History:

Current/Last Employer ____ Occupation ____________________

Work Experiences:

____

____

Military Service:

☐ Active ☐ Retired

☐ Army ☐ Air Force ☐ Navy ☐ Marine Corps ☐ Coast Guard ☐ Reserves

How you served: ____

Are you willing to help with a Hospice Veteran Program? ☐ Yes ☐ No ☐ More Information

Have you volunteered with other organizations? If yes, where and when?

____

____

Do you have access to transportation? ☐ Yes ☐ No

Other talents or hobbies: ____

____

How did you hear about Grand Lake Health Systems Volunteer Program?

- ☐ Newspaper
- ☐ Facebook / Grand Lake Health System Website
- ☐ Grand Lake Health System Employee
- ☐ Church Bulletin
- ☐ Health Fair
- ☐ Other ______________________________________

Area of Volunteering Interest:

- ☐ Grand Lake Hospice
- ☐ Joint Township District Memorial Hospital

Two Personal References: (not related to you):

Last Name ____ First Name _______________________________

Address _________________________________ City ______________________ State __________ Zip ____

Best Number to contact ______________________________ Relation _________________________________

Last Name ____ First Name _______________________________

Address _________________________________ City ______________________ State __________ Zip ____

Best Number to contact ______________________________ Relation _________________________________

Check box:

- ☐ I give Grand Lake Health System permission to conduct a criminal background check for volunteers 18 yrs. and older.
- ☐ I give Grand Lake Health System permission to take a photo for use on a volunteer identification badge.

By signing this application, I state that the information is true and correct to the best of my knowledge. If the Grand Lake Health System Volunteer Program requires additional information to process this application the potential volunteer will be contacted. If there are questions or concerns please discuss with the Volunteer Development Coordinator.

Applicant Signature ____ Date______________

Signature of Parent or Guardian if applicant is under 18 years of age ____________________________________

Return Application to:
Grand Lake Health System
Joint Township District Memorial Hospital
Attn: Volunteer Development Coordinator
200 St. Clair Street
St. Marys, Ohio 45885
Phone: 419-394-3387 ext. 2808