



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?

- | | |
|--|--|
| <input type="checkbox"/> Newspaper | <input type="checkbox"/> Church Bulletin |
| <input type="checkbox"/> Facebook / Grand Lake Health System Website | <input type="checkbox"/> Health Fair |
| <input type="checkbox"/> Grand Lake Health System Employee | <input type="checkbox"/> 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