

Volunteer Application

If you print it out, you can fax the completed form to: 618.463.7705.

Or you can mail the completed application to:

Alton Memorial Hospital
Auxiliary & Volunteers
One Memorial Drive
Alton, Illinois 62002

First Name_____

Middle Initial_____ Last Name_____

Address_____

City_____ State_____ ZIP Code _____

E-mail_____

Home telephone_____

Emergency telephone_____

Business telephone_____

Cell phone_____

Is anyone else at this address a volunteer here? _____Yes _____No

If yes, what is their name?_____

Have you ever served as a volunteer with us before? _____Yes _____No

If yes, what year(s)_____

Date of birth_____

Spouse's name (if married)_____

Education level (check all that apply)

_____clerical skills _____high school _____some college _____college degree

Are you retired? _____Yes _____No

Current employer_____

Recent former employer_____

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List any skills that can be used in health care

List any business or hospital equipment you can operate

Day(s) and time(s) you would like to volunteer

Day_____ Time_____

Day_____ Time_____

Day_____ Time_____

Areas of the hospital you are interested in working in (if available)

First choice_____ Second choice_____

How did you hear about the Alton Memorial Hospital Volunteer program?

_____newspaper _____physician _____employee _____walk-in _____other

Have you ever been convicted of a felony? _____Yes _____No

Please note:

All applications are reviewed and interviews scheduled when appropriate. Appointments are determined by volunteer interests and the needs of Alton Memorial Hospital. Upon assignment, you will receive applicable training.

Commitment:

I agree to give regular and dependable volunteer service to Alton Memorial Hospital.
I certify that the above information is true and accurate to the best of my knowledge

Applicant's name_____ Date_____