

# Southern Ohio Medical Center

*Very* Good things are happening here

**Volunteer Services**  
1805 27<sup>th</sup> Street  
Portsmouth, OH 45662

## Application to become a volunteer at SOMC

Name \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street City State Zip

Date of Birth (include year) \_\_\_\_\_ Home Phone with Area Code \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email Address \_\_\_\_\_

Employer/School \_\_\_\_\_

Alternate Contact (not living with you) \_\_\_\_\_

Their relationship to you \_\_\_\_\_ Phone \_\_\_\_\_

Do you have any physical conditions, which may limit your activities/abilities to perform any of the various volunteer jobs?  
\_\_\_\_\_ No \_\_\_\_\_ Yes If yes, please explain \_\_\_\_\_

When are you able to volunteer? (Please list day(s) and time) \_\_\_\_\_

Have you ever been convicted of a crime (felony, misdemeanor, DUI, etc.) other than a traffic violation?  
\_\_\_\_\_ No \_\_\_\_\_ Yes If yes, please explain \_\_\_\_\_

Note: Conviction of a crime is NOT an automatic bar to placement as a volunteer. All circumstances will be considered.

## References

Please list two people we can call for a reference.

\_\_\_\_\_  
Name Address Phone

\_\_\_\_\_  
Name Address Phone

The following is a partial list of assignment areas. Please check any or all you are interested in.

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Cancer Center    | <input type="checkbox"/> Clerical/Call-In | <input type="checkbox"/> Door Greeter       | <input type="checkbox"/> Employee Health    |
| <input type="checkbox"/> Gift Gallery     | <input type="checkbox"/> Grounds          | <input type="checkbox"/> Guild Member       | <input type="checkbox"/> Heart & Vascular   |
| <input type="checkbox"/> Hospice          | <input type="checkbox"/> Human Resources* | <input type="checkbox"/> Laundry            | <input type="checkbox"/> LIFE Center Rehab  |
| <input type="checkbox"/> Medical Imaging* | <input type="checkbox"/> Nursing Unit     | <input type="checkbox"/> Nutrition Services | <input type="checkbox"/> Safety/Risk Mgmt.* |
| <input type="checkbox"/> Same Day Surgery | <input type="checkbox"/> Social Services* | <input type="checkbox"/> Workforce Dev.*    |   |

\*Intern Locations

- |                                 |                                  |
|---------------------------------|----------------------------------|
| <input type="checkbox"/> Intern | <input type="checkbox"/> Pre-Med |
|---------------------------------|----------------------------------|

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

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### For Volunteer Office Use Only

COVID Vaccination \_\_\_\_\_

FLU Vaccination (October-March) \_\_\_\_\_ TB Administered, Step 1: \_\_\_\_\_ Step 2: \_\_\_\_\_

Orientation Date \_\_\_\_\_ Interviewer \_\_\_\_\_

Comments \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Start Date \_\_\_\_\_

Assignment \_\_\_\_\_

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To whom it may concern:

I, \_\_\_\_\_ hereby authorize any representative of Southern Ohio Medical Center bearing this release, or a copy thereof, to obtain any information in your possession pertaining to my education, work experience or judicial records including but not limited to: Academic achievement, attendance, athletic, personal history and disciplinary records; credit records; and arrest, conviction (including but not limited to felony, misdemeanor and DUI convictions), or criminal records.

I hereby release you, as the custodian of such records, in any school, college, university or other educational institution, credit bureau, consumer reporting agency or law enforcement agency, its officers, employees or related personnel, both individually and collectively from any and all liability for damages of whatever kind, which may at any time result to me, my heirs, family or associates because of the compliance with this authorization or any attempt to comply with it.

Should there be any questions as to the validity of this release, you may contact me as indicated below.

Upon signing, this release becomes an official company document. Falsification or providing misleading information may result in a withdrawal of employment offer, or removal from position (if already employed).

.....  
Signature \_\_\_\_\_ Date \_\_\_\_\_

Maiden Name \_\_\_\_\_ Other name used \_\_\_\_\_

SSN \_\_\_\_\_ Date of birth \_\_\_\_\_

Please list below your current and all previous addresses within the last five years. (Use an additional sheet if necessary)

Present Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Last Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Previous Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Signed \_\_\_\_\_

(Volunteer Department Representative)

Remarks \_\_\_\_\_

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## Understanding and Release Statement

I hereby release Southern Ohio Medical Center, employees, officers, members of the Board of Directors and members of the medical and clinical staff from any responsibility related to any illness or injury that may occur while volunteering at SOMC.

As a volunteer, I understand that I will not receive compensation or benefits for my services.

\_\_\_\_\_  
Volunteer

\_\_\_\_\_  
Date

## Confidentiality Statement

I understand and agree that I must hold in strictest confidence any observation I may make or hear regarding any patient, patient's family and staff.

\_\_\_\_\_  
Volunteer

\_\_\_\_\_  
Date