

AULTMAN HOSPITAL VOLUNTEER SERVICES DEPARTMENT  
ADULT VOLUNTEER APPLICATION

Name \_\_\_\_\_ Mrs. Mr. Miss Ms. (Please Circle)  
First M. Last

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone number \_\_\_\_\_ Alternate phone number \_\_\_\_\_

Birth Date \_\_\_\_\_ E mail address (if applicable) \_\_\_\_\_  
Month/day /year optional

Education: High School \_\_\_\_\_ College \_\_\_\_\_

Work Experience: Name of employer \_\_\_\_\_ Approx dates of employment \_\_\_\_\_  
Type of work \_\_\_\_\_

Volunteer Experience: Where? \_\_\_\_\_ When? \_\_\_\_\_  
Type of Service \_\_\_\_\_

Hobbies, skills, special interests: \_\_\_\_\_

Volunteer goals \_\_\_\_\_

Community affiliations \_\_\_\_\_

Reference: (List 1 family member and job experience or a volunteer experience) You must have at least two references with name, phone number, and relationship.  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever been employed at any Aultman facility? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, list department(s) and dates of employment \_\_\_\_\_

Do you have any medical conditions you think we should be aware of? \_\_\_\_\_ If so, what? \_\_\_\_\_

Emergency contact information: Name \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Alternate Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Do you accept that there will be certain requirements in connection with your training and assignment that must be met? \_\_\_\_\_

*I certify that all of the above information is true and accurate.*

Signature \_\_\_\_\_ Date \_\_\_\_\_ **SEE ATTACHED PAGE**

**After all forms are filled out and signed, mail them back to:**

**Aultman Hospital Volunteer Services  
2600 6<sup>th</sup> St SW  
Canton, OH 44710**

**FOR OFFICE USE ONLY**

Received \_\_\_\_\_ Interview \_\_\_\_\_

Orientation \_\_\_\_\_

**Then in 4 or 5 days, call 330-363-6368 to set up an interview.**

**Appointments taken Monday – Friday 8:30 a.m. – 4 p.m.**

**AULTMAN HOSPITAL  
VOLUNTEER DEPARTMENT  
2600 SIXTH ST SW  
CANTON, OH 44710  
Fax # 330- 580-5537**

**This must be completed before  
first day that volunteer begins**

CONFIDENTIAL

To: The Director of Volunteer Services

---

(Volunteer)

---

(Address)

---

(City, State, Zip Code)

The above named is free from contagious disease, and there is no  
contra-indication to her/his performing volunteer activities at Aultman Hospital

Remarks: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

---

(Doctor's Signature)

---

(Print Doctor's Name)

---

(Date)

Revised 11/06