ProMedica Defiance Regional Hospital
Volunteer Application

Name _____ Date _____

Address _____

Home phone _____

Birthdate _____ Email address _____

Emergency contact _____

Relationship _____ Phone number _____

How did you hear about the volunteer opportunities at Defiance Regional Hospital? _____

_____

What are you interested in volunteering? _____

_____

Do you know anyone who is employed or volunteers at Defiance Regional Hospital? _____

_____

List three personal references with complete name, address, and phone number (not relatives):

1. _____

2. _____

3. _____

The information provided on this application is accurate and correct to the best of my knowledge.

Signature _____

(Your signature indicates your approval for us to check your references.)

If the applicant is under the age of 18, a parent of guardian must sign. I have read the information and I give permission for my son/daughter to volunteer at Defiance Regional Hospital. If an emergency arises while my son/daughter is on duty and reasonable attempts to contact me at *(phone number)* _____ are unsuccessful, I give consent for the administration of treatment deemed medically necessary.

Signature of Parent/Guardian _____ Date _____