



Adult Volunteer Application

Volunteers serve Doctors Hospital of Augusta without salary, and work within the hospital under the supervision of specified personnel and the Volunteer Coordinator. To be considered, the following must be completed and submitted to the Volunteer Manager.

Application Drug Test Consent COVID Vaccination Background Form Immunization Record

Name: _____ Date: _____

Address: _____ Email: _____

Date of Birth: _____ Age: _____

Cell Phone: _____ S M L XL 2XL

Education/Degree: _____

Work Status: Employed Unemployed Retired Homemaker

If presently employed, name of company: _____ Work Phone: _____

Position: _____ Work hours and days: _____

I would like to volunteer in (list top three areas/departments of preference, or write *Chaplain*):

1. _____
2. _____
3. _____
4. _____
5. _____

Volunteer Availability: (Please circle the days and times you are available to work.)

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
EVE	EVE	EVE	EVE	EVE	EVE	EVE

Were you referred by a volunteer? Who? _____

How did you hear about volunteering at Doctors Hospital of Augusta?

Another volunteer Senior Center Church

What do you hope to gain from your volunteer experience?

Have you served in a health care setting before? _____ **No** _____ **Yes** **If yes, describe the experience:**

Are there any work conditions you must avoid/limitations to health?

The information provided in this application is true in all respects, without any willful omissions.

It is the policy of this organization to provide equal opportunity to persons regardless of race, religion, age, gender, disability or any other classification in accordance with federal, state, and local statutes, regulations and ordinances.



As a volunteer, I...

- Agree to attend the volunteer orientation and train until I am competent to perform the required duties;
- Agree to comply with all the rules and regulations of the hospital and the Volunteer Department;
- Understand that I may be dismissed from my duties for willful wrong doing or negligence and/or performing duties outside of my service description;
- Agree to call my assigned area or volunteer office as soon as possible when I have scheduling changes;
- Understand that Doctors hospital of Augusta is not obligated to utilize my services as a volunteer nor am I obligated to accept the volunteer assignment offered;
- Agree to uphold the confidentiality agreement with the hospital.

I acknowledge and have read the statements above and agree to abide by the expectations of the Volunteer Program and Coordinator, as well as those of Doctors Hospital of Augusta.

Signature: _____ Date: _____

Doctors Hospital of Augusta Volunteer Services
3651 Wheeler Road
Augusta, Georgia 30909
(706) 651-3590

It is the policy of this organization to provide equal opportunity to persons regardless of race, religion, age, gender, disability or any other classification in accordance with federal, state, and local statutes, regulations and ordinances.