



ORO VALLEY HOSPITAL

Volunteer Application

Name _____
Last First Middle Initial

Address _____

City/State/Zip _____ Phone _____

What day(s) do you wish to volunteer? _____

What shift do you wish to volunteer?

___ AM (8 a.m. to noon) ___ PM (Noon to 4 p.m.) ___ EVE (4 p.m. to 8 p.m.)

Areas of Interest

___ Information Desk

___ Waiting Room

___ Urgent Care

___ Messenger

___ Patient Contact

___ Clerical

___ Gift Shop

Do you prefer working alone? _____

Working with a group _____

Have you ever been convicted of a felony Yes [] No []

Have you ever been convicted of a misdemeanor Yes [] No []

Are you seeking to volunteer for court ordered community service Yes [] No []

In Case of Emergency, Please Notify

Name: _____ Phone: _____

Relationship: _____

Doctor's Name _____ Phone: _____

Please check the Volunteer Program you are applying for:

___ Senior Program (18 years and over)

___ Junior Program (ages 15 - 18)

***Please include

✿ 2 letters of recommendation

✿ Proof of MMR Vaccinations _____ or MMR Immunity _____

Parental Consent for Applicants Under Age 18

I hereby give permission for _____ to serve as a volunteer at
(Please Print)

Oro Valley Hospital. I give the above named hospital permission to do whatever testing or x-rays are required by the Employee Health Department. In the event of an accident or injury to the above named while in the hospital, I give permission for him/her to receive emergency treatment by a member of the hospital staff until the family and/or family physician can be notified.

Date of Birth of Applicant _____
Parent /Guardian Signature _____
Relationship: _____ Date: _____

Certification and Authorization

I certify that the information I have provided is true and complete to the best of my knowledge. I understand that misrepresentation, falsification, or omission of information may disqualify me from further consideration for volunteering, or may result in my termination as a volunteer.

If accepted as a volunteer, I understand that I must abide by all of the policies and regulations of Oro Valley Hospital.

I authorize Oro Valley Hospital to investigate all statements contained in this application and to make inquiries of my personal references and medical history, as well as other related matters as may be necessary for determining my eligibility as a volunteer. I hereby release physicians, employers, schools or individuals from all liability in responding to inquiries relating to my volunteer application.

Name: _____ Date: _____

Please Return to:

Joanie Johnson
Manager, Volunteer Services
Oro Valley Hospital
1551 E Tangerine Rd
Oro Valley, Arizona 85755