



Section I: Personal Information

Last Name: _____ First Name: _____

Street Address: _____ Apt/Unit: _____

City: _____ State: _____ Zip Code: _____

Home Phone: () _____ Cell Phone: () _____

Email: _____

Section II: Emergency Contact Information

Emergency Contact: _____ Relationship to you: _____

Home Phone: () _____

Work Phone: () _____

Cell Phone: () _____

Section III: Questionnaire

1. Why are you interested in volunteering?

2. Is there anything that may adversely affect your ability to perform volunteer work?

() yes () no

If yes, please describe in detail:

3. Are there any accommodations needed in order for you to safely and competently perform volunteer work as required?

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, rules and regulations of Southampton Memorial Hospital.

I authorize Southern Virginia Regional Medical Center to investigate all statements contained in this application and to make inquires 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 inquires relating to my volunteer application.

Name: _____

Date: _____