

**WEIRTON MEDICAL CENTER AUXILIARY**

601 Colliers Way Weirton, WV 26062

**VOLUNTEER**

**Application**

**Applicant (Please print clearly)**

|                          |                   |               |   |                     |
|--------------------------|-------------------|---------------|---|---------------------|
| <b>Last Name Initial</b> | <b>First Name</b> | <b>Middle</b> | <b>Birthdate</b> <small>(year optional)</small> | <b>Today's Date</b> |
| <b>Home Address</b>      | <b>City</b>       | <b>State</b>  | <b>Zip</b>                                      | <b>Phone</b>        |

**Education: (Please circle last year completed)**

High School 1 2 3 4  College 1 2 3 4  Graduate 1 2 3 4

**Employment**

Are you presently employed?  No  Yes—If yes, hours per week \_\_\_\_\_

Employer's Name Address Phone

Can you be contacted at work?  No  Yes Phone Number at work

**Previous Work Experience:**

**What type of volunteer work would you like to do? (please check)**

- Information desk                       Patient Mail                       Clerical
- Gift Shop                                       Coffee Cart                       Gift Cart
- Special Events                               Other \_\_\_\_\_

**Days and time preferred ----- Indicate hours available----- include AM or PM**

| Sunday | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday |
|--------|--------|---------|-----------|----------|--------|----------|
|        |        |         |           |          |        |          |

Please Explain Briefly Your Reasons for Volunteering:

Previous or Present Volunteer Experience:

Hobbies or Special Interests:

Further Comments or Information you might wish to offer:

References: Please list two personal references.

| Name | Address | Phone |
|------|---------|-------|
|------|---------|-------|

| Name | Address | Phone |
|------|---------|-------|
|------|---------|-------|

Person to be notified in case of emergency.

Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_ Relationship \_\_\_\_\_

I authorize investigation of all statements contained in this application.

Date: \_\_\_\_\_ Applicant's Signature \_\_\_\_\_

Please return application to:  
Weirton Medical Center  
Gift Shop c/o Sondra Weigel  
601 Colliers Way  
Weirton, WV 26062

For Volunteer Office Only: \_\_\_\_\_  
Date of Receipt of Application \_\_\_\_\_  
General Orientation \_\_\_\_\_  
Patient Training \_\_\_\_\_