

**Parkwest Medical Center**  
**Volunteer Application**  
(ages 18 and up)

Date \_\_\_\_\_

Birthday \_\_\_\_\_ Social Security # \_\_\_\_\_

Name \_\_\_\_\_ Phone # \_\_\_\_\_ Cell # \_\_\_\_\_  
First Middle Initial Last

Address \_\_\_\_\_ E-mail address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Current/Former Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

Education and Special Training \_\_\_\_\_

Volunteer Experience or Organizations \_\_\_\_\_

\_\_\_\_\_

Special Interests, skills, hobbies, etc. \_\_\_\_\_

\_\_\_\_\_

Foreign languages \_\_\_\_\_ Sign language \_\_\_\_\_

Community Affiliations (ex: Churches, clubs, etc.) \_\_\_\_\_

Have you ever been convicted of a crime (other than minor traffic violations)? \_\_\_\_\_

If yes, explain giving dates: \_\_\_\_\_

NOTE: A conviction record will not necessarily disqualify you from a volunteer position. Such factors as age and time of offense, seriousness and nature of the violation will be taken into account.

In case of emergency, call: \_\_\_\_\_ Phone \_\_\_\_\_  
Relationship to you: \_\_\_\_\_

How did you hear about the Parkwest Medical Center Volunteer Program? \_\_\_\_\_

If referred by current Parkwest Volunteer or employee, please list name \_\_\_\_\_

Please list any physical limitations or disabilities you might have \_\_\_\_\_

\_\_\_\_\_  
(This will help us to determine the best position for you)

LIST THREE REFERENCES OTHER THAN RELATIVES:

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

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

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

- I authorize inquiries of all statements contained in this application as may be necessary in arriving at a volunteer position and I authorize my references to release information pertaining to my character and dependability.
- I understand that all volunteers are required to furnish three personal references before beginning work at Parkwest Medical Center.
- I agree to abide by the policies and procedures of the Volunteer Services Department and to hold all information regarding patients as strictly confidential. I understand that failure to abide by the Confidentiality Policy is grounds for being dismissed from my volunteer service.
- I understand that all information on this application is confidential and will not be released without my written permission.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**NOTE:** Openings are not always available for the service areas in which you are most interested. The Volunteer Services Coordinator will work with you in selecting an alternate service area. From time to time it may be necessary for a prospective volunteer to wait until an appropriate service area is available. Interviews are conducted when volunteer openings become available.

Days available (please circle)	M	Tu	W	Th	F	Sa	Su
Hours available (please specify)	_____						
Length of service intended:	3 months _____	1 year _____	Indefinitely _____	Other (Specify) _____			
Volunteer area(s) preferred	_____			Volunteer area assigned	_____		

If your availability or schedule preference changes or if you have any questions, please call Becky Boyd, Volunteer Coordinator, 373-1556

PLEASE COMPLETE ALL INFORMATION REQUESTED ABOVE AND RETURN TO:

Becky Boyd, Volunteer Coordinator  
Parkwest Medical Center  
9352 Park West Blvd.  
Knoxville, TN 37923

Phone: 865-373-1556  
Fax: 865-373-1567