

# APPLICATION FOR VOLUNTEER SERVICE

## Highlands ARH Regional Medical Center

*(To be completed by applicant)*



Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Preferred method of contact: \_\_\_ Phone \_\_\_ E-mail \_\_\_ Text SS#: \_\_\_\_\_

References: Please include name, relationship, and phone number of two personal references.

1. \_\_\_\_\_

2. \_\_\_\_\_

Volunteer Area(s) of Interest:

\_\_\_\_\_

Please list the days of the week and times that you are available to volunteer:

\_\_\_\_\_

Person to Contact in Case of Emergency:

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

By my signature below I certify that I am at least 18 years of age and in good physical and mental condition to serve as a volunteer. I agree to uphold the purpose and policies of the volunteer program of Appalachian Regional Healthcare.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Return Completed Application in person, by mail, or e-mail to:

Jamie Justice  
Highlands ARH Regional Medical Center  
5000 KY Route 321  
Prestonsburg, KY 41653  
E-mail: [jjustice@arh.org](mailto:jjustice@arh.org)

Questions, please call: 606-886-7606