

# APPLICATION FOR VOLUNTEER SERVICE

## Morgan County ARH Hospital

(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. \_\_\_\_\_

**Area(s) of Interest:** Please check any area(s) in which you are willing to volunteer. Space is provided if you would like to add more information below.

\_\_\_\_\_ Information Desks \_\_\_\_\_ Gift Shop

\_\_\_\_\_ Other: \_\_\_\_\_

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:

Amber Cole  
Morgan County ARH Hospital  
476 Liberty Road  
West Liberty, KY 41472  
E-mail: [acole2@arh.org](mailto:acole2@arh.org)

Questions, please call: 606-743-3186