APPLICATION FOR VOLUNTEER SERVICE

Whitesburg ARH Hospital

(To be completed by applicant)

ARH Volunteer Services

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:

Rachel Breeding
Whitesburg ARH Hospital
240 Hospital Road
Whitesburg, KY 41858
E-mail: rbreeding@arh.org

Questions, please call: 606-633-3572