APPLICATION FOR VOLUNTEER SERVICE

Mary Breckinridge 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. ______________________________

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:

Mallie Noble
Mary Breckinridge ARH Hospital 130 Kate Ireland Drive
Hyden, KY 41749
E-mail: mnoble1@arh.org

Questions, please call: (606) 672-1100