

APPLICATION FOR VOLUNTEER SERVICE

Tug Valley 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. _____

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:

Christy Hall
Tug Valley ARH Regional Medical Center
260 Hospital Drive
South Williamson, KY 41503
E-mail: chall@arh.org

Questions, please call: 606-237-1711