APPLICATION FOR VOLUNTEER SERVICE

Mary Breckinridge 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. _____

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