Rome Health
An affiliate of St. Joseph's Health

Volunteer Application

Name:____DOB:______/_______
First Last Day / Month

Address:____
Street City State Zip

Cell Phone:______________________________Home Phone_______________________

Email Address:____

Emergency Contact:__________________________P hone:________________________

Relationship:____________________ Address:___________________________________

Preferred volunteering position:____

Other volunteer experience:____

References: (Two persons, not related to you, that you have known for several years)

Name:____ Phone Number:______________

Name:____Phone Number:_______________

Preferred days and hours:

- ☐ Monday ____________
- ☐ Tuesday____________
- ☐ Wednesday__________
- ☐ Thursday___________
- ☐ Friday_____________
- ☐ Saturday____________
- ☐ Sunday_____________

Have you ever been convicted of a crime, other than a traffic violation?

- ☐ Yes
- ☐ No

If yes, please explain:____

I certify that the answers given herein are true and complete to the best of my knowledge. I authorize investigation of all statements contained in this application for volunteering and understand that any false statement may be cause for termination. I consent to any and all related examinations required by Rome Health. I accept the invitation to volunteer on behalf of Rome Health and understand that there will be no financial payment for my service.

Signature:____ Date:_______________