ROCHESTER
REGIONAL HEALTH
Clifton Springs Hospital
& Clinic

VOLUNTEER APPLICATION - ADULT

Mr. ___Mrs. ___Miss ___

_____ _____
(Last name) (First name)

Social Security # _____ -____ - _____ DOB_____ Telephone:_____

Home Address:_____
Street (City) (State) (Zip Code)

E-mail Address _____

Name & Telephone # of Emergency Contact:

_____

Special Skills & Volunteer Experience:

_____

_____

Days & Hours Available: _____

Other than a misdemeanor, have you ever been convicted of a criminal offense? Yes _____ No _____

I attest that the information I have given above is the truth to the best of my knowledge:

_____ _____
(Signature) (Date)

For office use only:

Assigned to: _____

Volunteer Office Approval: _____