ALBANY MED Health System
SARATOGA HOSPITAL

211 Church Street
Saratoga Springs, NY
12866-1090
tel. 518-587-3222

Saratoga Hospital Volunteer Application

Name (Print) **:**_____

Address: _____

Email: _____ **Phone:** _____

If you are under 18 years, do you have a work permit?..... Yes No N/A

Have you ever volunteered elsewhere?.....Yes No If Yes, where?_____

Are you required to volunteer?.....Yes No If Yes, by whom?_____

How did you hear about our volunteer program? _____

Why do you wish to volunteer at Saratoga Hospital? _____

EDUCATION ***(Please circle last grade/year completed)***							
High School	9	10	11	12		High School Name	
College	1	2	3	4	5+	College Name	Degree/Major

WORK EXPERIENCE *(Please complete for your most recent employer)*

Employer _____ Job Title _____

Reason for Leaving _____ Job Duties _____

AVAILABILITY ***(Please check the boxes for the days and times you are most often available to volunteer):***

	Sunday	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
Morning							
Afternoon							
Evening							

Skills ***(Please check all that apply):***
__Clerical/Filing/Copying/Mailing
__Computer Literacy
__Errands/Delivery/Driving
__Greeter/ Escort
__Other_____

Preferred Service Area(s)
__Treasures Boutique
__Gift Shoppe
__ Medical/Surgical Floor
__ Radiation Oncology Center
__ Information Desk
__Medical Library
__Pastoral Care
__Dog Therapy
__Urgent/Emergency Care
__Other_____

Please list two (2) professional (non-family) references (name, title, email address and/or phone)

1. _____
2. _____

Applicant's Certification and Agreement

If I misrepresent or deliberately leave out a fact in my application, I may be refused a volunteer position or, if presently a volunteer, I may be terminated. The Hospital has my authorization to thoroughly investigate my work, medical, and personal history. I will hold no person liable for giving or receiving information in this investigation. I may terminate my volunteer position at any time without notice or cause and the Hospital may terminate or modify the relationship at any time without notice or cause. In consideration of the position, I agree to conform to the rules and regulations of the Hospital. Any offer of a volunteer position is contingent on successful completion of a health assessment and criminal background check. Any doctor, hospital or testing laboratory may conduct medical tests to determine my ability to perform duties now or in the future and may release all information necessary to the Hospital. I understand that my status as a volunteer is for no definite period of time. I have read and agree to the above and hereby certify that the facts that I have provided in my Volunteer Application are true and complete.

Signature _____ **Date**_____