



Volunteer Application

Name: _____ Phone (daytime): _____

Address: _____
Street / P.O Box City State Zip

Email: _____

What WRH facility are you applying to? White River Medical Center Stone County Medical Center

Marital Status: Single Married If married, spouse's name: _____

Age Group: 18-25 26-34 35-49 50-60 over 60

Birth Month: _____

Education (Highest Level Completed)

No High School Diploma High School Diploma/GED/Alternative Credentials

Some College Bachelor's degree Master's Degree, Professional Degree or Doctorate Degree

Special Training: _____

Hobbies, interests, or other special skills: _____

Computer skills: _____

Healthcare areas of interest: _____

Previous work experience: _____

Previous volunteer experience: _____

How did you learn about the volunteer program? _____

If referred by a WRH volunteer, please provide their name: _____

Have you ever been convicted of a felony? Yes No

If yes, please provide date and details: _____

Day(s) of the week you are available to Volunteer:

Mon. Tues. Wed. Thurs. Fri. Sat Sun.

Please check the area where you prefer to Volunteer:

- Patient/family service area Visitor/family service area
 Gift shop Staff-support service area

How did you become interested in the volunteer program? _____

Have you previously served as a volunteer for White River Health (WRH)? Yes No

Are you currently employed, or have you been previously employed by WRH? Yes No

Please provide contact information for two personal references: (*Please exclude relatives*)

Name: _____ Daytime Phone: _____

Name: _____ Daytime Phone: _____

Emergency contact: _____ Daytime Phone: _____

Relationship to applicant: _____

The information I have provided is accurate to the best of my knowledge. Your signature indicates approval to contact references provided. The organization is not obligated to provide volunteer placement, nor are you obligated to accept the volunteer position offered. Volunteer opportunities are provided without regard to religion, creed, race, national origin, age, or sex orientation. WRH Volunteers are subject to the regulations of the Health Privacy Portability and Accountability Act (HIPAA) and are required to sign a Confidentiality Statement.

Applicant Signature: _____ Date: _____

White River Health Volunteer Services
1710 Harrison St., P.O. Box 2197
Batesville, AR 72501

To check on the status of your application or to arrange an interview, please call 870-262-1809

Annie Solis, White River Medical Center, Marketing Manager

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Celena Beach, SCMC Director of Volunteer Services

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Thank you for your interest in joining our Volunteer Team