

TWIGS Application



TWIGS of Licking Memorial Hospital

Togetherness, Willingness, Imagination, Giving, Sharing

TWIGS:

Number

Name:

Last

First

Middle





**TWIGS of
Licking Memorial Hospital**
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TWIGS Application

Today's date: _____

GENERAL INFORMATION

Mr., Mrs., Ms., Miss: _____
Last name First name Middle initial

Address: _____
Street City State Zip Code

Telephone: Home: (____) _____ Cell: (____) _____

Email: _____

Birthday: _____

Completed education: High school College Postgraduate degree

Degree(s): _____

Work status: Employed Unemployed Retired Homemaker

Last place of employment: _____

If presently employed, name of company: _____ Work phone: (____) _____

Position: _____ Work hours and days: _____

IN AN EMERGENCY, PLEASE NOTIFY:

Name: _____

Address: _____

Home phone: _____ Work phone: _____

Have you ever committed, been convicted of, pleaded guilty to, pleaded no contest to or entered a plea to a felony or misdemeanor?

No Yes If yes, please explain: _____

SKILLS / INTERESTS

Do you currently work in retail or have you worked in retail in the past? [] Yes [] No

If yes, please explain: _____

How did you become interested in TWIGS? _____

Are there any work activities or conditions that you must avoid? _____

Any additional information that you care to add: _____

PERSONAL REFERENCES

Please do not use relatives as references.

Two references are required, and at least one reference for whom you have worked is preferred.

1. Name: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Phone: _____

2. Name: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Phone: _____

3. Name: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Phone: _____

CONFIDENTIALITY/CONSENT

The information provided in this application is true in all respects without any willful omissions. I give my consent for a representative of the Volunteer Office or TWIGS to contact the references listed and to do a credit check and/or background check.

As a TWIGS volunteer, I would...

- I agree to complete the assigned training period until I have been deemed competent to perform the required duties.
- I agree to comply with all the rules and regulations of the Hospital and TWIGS.
- I understand that I may be dismissed from my duties for willful wrongdoing or negligence and/or performing duties outside of my service description.
- I agree to follow established protocol should I not be able to work my assigned shift.
- I understand that TWIGS is not obligated to utilize my services as a volunteer, nor am I obligated to accept the volunteer assignment offered.
- I agree that I am performing duties as a volunteer and am not entitled to compensation.

CONFIDENTIALITY: It is the belief of this Hospital that all medical, financial, and personal information pertaining to a patient is confidential and is protected from unauthorized viewing, discussion, and disclosure. Therefore, TWIGS volunteers may review, use, or disclose patient information ONLY as it relates to the performance of their duties. Any unauthorized viewing, discussion or disclosure will provide grounds for immediate dismissal.

I acknowledge and have read the statements above and agree to abide by the expectations of TWIGS, the Volunteer Department, and LMHS.

Signed: _____ Date: _____

Opportunities for Volunteers are provided without regard to religion, creed, race, national origin, age, sex, or disability.

**Please return the completed application to:
Director of Development
Licking Memorial Hospital
1320 West Main Street
Newark, Ohio 43055
Development Department: (220) 564-4102**
