Confluence Health
Volunteer Application Form

Identification:
Name: Last: __________________________ First: __________________________ MI ______
Address: __________________________ Phone: __________________________
City: __________________________ State: ______ Zip Code: __________
Email address __________________________ Today’s Date: __________________________
Are you under 18 years of age? □ Yes □ No Date of Birth: ____/____/_____
Are you able to commit to at least 6 mos./100 hours of volunteer service? □ Yes □ No
Person to contact in case of Emergency: __________________________
Phone #: __________________________ Relationship: __________________________
Have you ever been employed at CWH? □ Yes □ No If Yes, when? __________

Work Preferences:
Please list areas of interest: __________________________
Date available to start: __________________________

Time Available:
□ Mon □ Tues □ Wed □ Thurs □ Fri □ Sat □ Sun
□ Morning □ Afternoon □ Evenings

Hours per shift: □ 2 hours □ 3 hours □ 4 hours □ Other
Number of shifts per week: __________
How did you learn about the volunteer program? __________________________

Prior Experience:
Volunteer: __________________________

Work: __________________________

____________________________
____________________________
Education

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<tr>
<th>Name of School</th>
<th>Field of Study</th>
<th>Graduated yes/no</th>
<th>Diploma/Certificate</th>
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**References:** (Must be over 18 and not an immediate family member.)

1. **Personal Reference:**

   Name: __________________________ Phone Number: __________________________

   Organization: __________________________

   Describe type and length of acquaintance:

   __________________________________________________________

   __________________________________________________________

2. **Employment Reference:** *(If no employment history, please list additional references)*

   Name: __________________________ Phone Number: __________________________

   Organization: __________________________

   Describe type and length of acquaintance:

   __________________________________________________________

   __________________________________________________________

**Important Notice:**

**I understand that my services are donated to Confluence Health without contemplation of compensation or future employment and given with humanitarian or charitable reasons.**

I consent to and authorize Confluence Health and its Volunteer office to request any information concerning criminal conviction record information from the Washington State Patrol Identification and Criminal History Section Pursuant to the Child/Adult Abuse Information Act, RCW 43.43.830 through 43.43.840.

Signature: __________________________ Date: __________________________

**Please attached a copy of your government issued ID**