



LECONTE
MEDICAL CENTER
Volunteer Services

Volunteer Services Adult Application

Date: _____

Personal Information

Name: _____

Address: _____

_____ *City* _____ *State* _____ *Zip*

Phone: (Home) _____ (W) _____ (C) _____

E-mail address: _____

Emergency Contact: _____ **Phone:** _____
(Family Member Name/Relationship)

Experience/History: Employment/Volunteer

Current Occupation: _____

Name/Address of most recent employer: _____

_____ **Phone:** _____

Education & Special Training: _____

Volunteer Experience/Organization: _____

Personal References
(These cannot be relatives)

1. **Name:** _____ **Phone:** _____

2. **Name:** _____ **Phone:** _____

3. **Name:** _____ **Phone:** _____

Were you referred by a current LeConte Volunteer? *(Please Circle)*

Yes, their name: _____ No

Hobbies and Skills _____

What else do you like to do in your spare time? _____

Skills: *(Please check all that apply)*

Typing People Person Filing Teaching

Organizing Art Work Retail Good phone skills

Computer knowledge *(please list programs with which you have experience:*

Other skills *(please list):*

Volunteer areas of interest: *(Please check all that apply)*

Clerical Food Services Nursing Home Gift Shop

Thrift Shop Engineering Information Desk Registration

Surgery Waiting Desk Fundraising Patient Follow-up calls (Discharge calls)

Other: _____

Days Available to volunteer: *(Please check all that apply)*

Monday Tuesday Wednesday Thursday Friday

Saturday Sunday *Weekend opportunities include: Thrift Shop & Nursing Home*

Preferred hours of the day to volunteer: _____

Are you a year-round local resident? Yes No

If no, what months are you available? _____

Have you ever been convicted of a crime (other than a minor traffic violation)?

Yes No

If you answer yes above, please explain and provide dates of offense(s): _____

(Note: A conviction record will not necessarily disqualify you from a volunteer position. Such factors as age and time of offense, seriousness and nature of the violation will be considered.)

I authorize the use of any information in this application to enable the Medical Center to verify my statements, and I authorize past employers, all references, and any other person to answer all questions asked by the Medical Center concerning my ability, character, reputation, and previous experience. I release all such persons from any liability or damages on account of having furnished such information.

I agree to abide by all rules, policies and regulations of the Medical Center.

Signature of Applicant: _____ Date: _____

Please complete all information in the application and return to the Volunteer Services Department in person (applications can be dropped off at the Information Desk), or via mail:

LeConte Medical Center
Attn: Volunteer Services
742 Middle Creek Road
Sevierville, TN 37862

If you have any questions please call 865.446.8400.



General Release to Conduct Consumer Reports

In connection with my application to become a hospital volunteer, I understand that investigative and/or consumer reports may be requested to provide information with regard to my qualifications to serve as a volunteer. These reports may contain public record information and may also include consumer credit reports, criminal records, driving records, education verification, prior employment verification, Workers Compensation claims history, or other information. I further understand that these reports or reference checks conducted by the Volunteer Services Department may also include the reason from separation from previous employers. I also understand that the Volunteer Services Department may request information from various Federal, State, Local and other agencies which may provide information regarding my past activities.

I hereby authorize any party or agency contacted by LeConte Medical Center to furnish the information referenced above. I hereby release from liability any and all individuals or entities who supply information to LeConte Medical Center in good faith and without malice concerning my competence as a volunteer, ethics, character or other volunteer qualifications. I further understand that LeConte Medical Center may rely without investigation, on information furnished by any such person or entity.

I understand that I have the right to make a request to use any vendor used by LeConte Medical Center to supply this information to obtain copies of the information it may have in its files with regard to me at the time of my request. I understand that the request will be honored upon proper identification and payment of any authorized fees. I further authorize ongoing requests for the information referenced above at any time during my volunteer commitment.

Please complete the information below. This information will be used for identification purposes only. Please print.

1. **Name:** _____ 2. **Social Security Number:** _____ - _____ - _____

3. **Current Address:** _____
Street City State Zip

4. **Birth date:** ___ / ___ / ___ (Month, day, year) 5. **Drivers License State:** _____ **Drivers License Number:** _____

6. **Gender:** Male Female 7. **Race** Caucasian African American Native American Hispanic Asian/Pacific Islander Other

8. **List any other names you may have used in the past, or any former name(s):** a. _____
b. _____ c. _____ d. _____

9. **Please list any previous addresses if you have resided at your present address for less than seven (7) years. Please print.**

a. _____ From _____ to _____
Street City State Zip Month/Year Month/Year

b. _____ From _____ to _____
Street City State Zip Month/Year Month/Year

c. _____ From _____ to _____
Street City State Zip Month/Year Month/Year

d. _____ From _____ to _____
Street City State Zip Month/Year Month/Year

Applicant's Signature

Date