UNIONTOWN HOSPITAL
Making a Healthy Difference in the Lives We Touch

Volunteer Services (724) 430-5671
WILL RIDE CAMPUS SHUTTLE DRIVER
VOLUNTEER APPLICATION

Name:_____

Address:_____

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

Phone: Home _____ **Work**_____

Email Contact: _____ **May we contact you by email? Yes No**

I am 21 years of age or older:_____ **Yes** _____ **No**

Person to contact in case of illness:

Name: _____ **Phone #:** _____

Do you have any relatives currently working at this hospital? If so, please list:

Name: _____ **Name:** _____

Have you ever plead guilty or been convicted of a misdemeanor or felony offense?

_____**Yes** _____**No If yes, specify:** _____

_____

Are there any conditions that would affect your ability to drive a shuttle cart? ❑ **Yes** ❑ **No**
If yes, specify: _____

Do you have a valid PA Driver's license and Insurance? ❑ **Yes** ❑ **No**

Your Availability:

Day: Monday Tuesday Wednesday Thursday Friday

Time: 8 am – 11am 11 am – 2 pm 2 pm – 5 pm

PLEASE NOTE:

Unless otherwise noted, I hereby give permission to Uniontown Hospital to investigate any and all information on this application. I further authorize my previous employers, personal references, and educational institutions to provide Uniontown Hospital with the requested information, and release them from any liability connected with the submission of this information.

I certify that all statements are true and correct to the best of my knowledge and belief.

I understand the first three months as a volunteer are probationary in nature. If I become a Uniontown Hospital volunteer, I agree to:

- Abide by the Uniontown Hospital policies and procedures.
- Keep all patient information and hospital business completely confidential at all times.
- Attend orientation and any other required educational training.
- Strictly adhere to my volunteer assignment description.
- Complete testing for TB prior to start date.

Signature _____ **Date** _____

The Uniontown Hospital volunteer program does not discriminate on the basis of race, color, sex, age, religious creed, national origin, ancestry or disability in the selection and placement of volunteers or in the provision of services.

Please complete this application and return to

Uniontown Hospital Volunteer Services
500 West Berkeley Street, Uniontown, PA 15401

By FAX: 724.430.8631

Or By Email: flasher@utwn.org

THE UNIONTOWN HOSPITAL
ADULT VOLUNTEER REFERENCE LIST

VOLUNTEER NAME: _____

Prior to beginning your assignment, you must have two positive references from adults who know you well enough to recommend you as a volunteer. Such persons may not be related to you.

Please list the names of two references below and provide a complete mailing address.

The Volunteer Office will mail a reference form to each person listed below:

PLEASE PRINT

Reference #1: Name _____

Title _____

Address _____

City/State/Zip _____

Reference #2: Name _____

Title _____

Address _____

City/State/Zip _____

Please return completed form to the Volunteer Office.

UNIONTOWN HOSPITAL
Making a Healthy Difference in the Lives We Touch

AUTHORIZATION AND RELEASE FORM FOR OBTAINING PENNSYLVANIA STATE POLICE CRIMINAL HISTORY BACKGROUND

As part of the procedure to process my volunteer application, or continued volunteer service, I authorize Uniontown Hospital to obtain a criminal history background check, and/or during my volunteer service, if selected, so as to update, renew, or extend my volunteer service utilizing the services of the Pennsylvania State Police to obtain a criminal history background report.

I understand that Volunteer Service with Uniontown Hospital may not be extended and/or if selected I may be terminated if I have been convicted of an offense which is related to the volunteer assignment for which I have applied.

I understand that Uniontown Hospital will pay the necessary fees associated with the background check.

_____
Social Security Number

_____
Date of Birth

_____
Print Name

_____ _____
Signature **Date**

UNIONTOWN HOSPITAL

Making a Healthy Difference in the Lives We Touch

MOTOR VEHICLE RECORD RELEASE CONSENT FORM

I _____(applicant) agree to allow Uniontown Hospital Volunteer Services to check my driving record prior to acceptance to the program and to check it periodically thereafter. I further agree to report to Volunteer Services Director immediately any license suspensions, serious accidents or offenses, or any other condition that may affect my ability to drive.

I understand that Uniontown Hospital Volunteer Services will use this information for volunteer purposes only and not furnish this information to a third party without my written consent.

Signed (applicant)_____

Print Name:_____

Date:_____

Drivers' License Number: _____State:_____