St. Croix Regional Medical Center (SCRMC)
Volunteer Application and Consent Form

NAME: _____
(Last) (First) (Initial)

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

HOME PHONE: (____) _____ **OTHER:** (____) _____

EMAIL ADDRESS: _____ **BIRTHDATE:** _____/_____/_____

Emergency Contact: _____
(Name) (Relationship)

Address: _____

Home Phone: (____) _____ Other: (____) _____

Are you presently employed? _____NO _____YES Employer: _____

May we contact you there? _____NO _____YES Phone: (____) _____

Are you a member of a local congregation? _____NO _____YES

Name of Church: _____

How did you learn about SCRMC? _____

Are you volunteering to fulfill a community service requirement? _____NO _____YES

If yes, required by: _____ How many hours required? _____

Name of High School/College attending: _____

Activities (volunteer/school): _____

_____

Community Involvement: _____

Career Interest: _____

Health restrictions or physical limitations that could affect your volunteer placement: _____

_____

Please check day(s) and time(s) that are convenient for you to volunteer:

DAYS	MON	TUE	WED	THU	FRI	SAT	SUN
Morning							
Afternoon							
Evening							

Volunteers are vital to SCRMC's patients, families, visitors, staff

PLEASE CIRCE VOLUNTEER AREA(S)/ACTIVITIES OF INTEREST TO YOU

Departments:
Administration
Business Office
Clinic
Education/Marketing
Emergency Room
Human Resources
Information Desks
Kitchen
Lab
Maintenance
Medical Records
Medical/Surgical Unit
Obstetrics
Oncology
Pharmacy
Physical Rehabilitation
Quality Assurance
Radiology
Social Services
Surgery

Events/Fundraisers:
Bake Sales
Blood Drive
Book Sales
Cake Walk
Camps
Conferences
Disaster Drills
Fairs
Gift Shop
Love Lights
Open Houses
Parades
Relay for Life
Salad Luncheon
Tours

Skills:
Baking
Clerical (filing, typing, mailings)
Computers
Decorating
Driving
Entertainer: _____
Gardening
Knitting/Crocheting
Leadership
Musician: _____
Newsletter
Pastoral Care
Pet Therapy
Quilting
Scrapbooking
Sewing
Telephoning
Writing
Other: _____

REFERENCE FOR YOUTH VOLUNTEERS (14 – 17 years old)

Teacher's Name: _____

School: _____ Phone: (_____) _____

YOUTH INFORMATION

School: _____

Your Grade: _____ Graduation Year: _____

PERMISSION FOR YOUTH VOLUNTEER

I have read the Application/Consent Form and give _____
Permission to be a youth volunteer at St. Croix Regional Medical Center.

Parent/Guardian Signature: _____ Date: _____
Youth Signature: _____ Date: _____

REFERENCE FOR ADULT VOLUNTEER

I hereby authorize SCRMC to obtain information from the following individual for the purpose of a personal reference.

Reference Name (other than relative): _____

Address: _____ Phone: (_____) _____

I understand SCRMC volunteers are required:

- to have a background check, and I agree to complete the necessary forms for Human Resources.
- to have a health screening/test (Mantoux) provided by SCRMC, and I agree to complete with Infection Control.
- to have a general orientation, and I agree to complete with Volunteer Services.

Applicant Signature _____

Date: _____

Please contact or return application to:
Mickey Gebhard, Volunteer Manager
St. Croix Regional Medical Center
235 State Street
St. Croix Falls, WI 54024
715-483-0331