Memorial Hospital Auxiliary
Volunteer Service Application

Volunteers are the lifeblood if every hospital in our country.
A volunteer is a person who willingly and without pay gives of their
time, talent and energy for a cause or project they believe in.

Name (Please Print)____

Home Address____

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Phone____________________________________Birthday_____________________________

E-mail____

Emergency Contact____

Relationship________________________________Phone______________________________

Referred by____

Name of Personal Reference (not related and over 25 years of age)_______________________

____Phone_____________________________

Tell us about yourself____
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Family____
____

Education____
____

Work Experience____
____

Volunteer Experience____
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Reason for Volunteering____
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Please return completed application to PMHA Gift Shop or mail to
PMHA Membership, 200 Memorial Drive, Luray VA 22835
Membership dues of $5.00 will be payable at interview.
Thank you for your interest.

Confidentiality Statement

I understand that all patient information which includes, but is not limited to, health, history, medical treatments, diagnostic and personal information is strictly confidential. This also includes that fact that a patient has been admitted or has received services.

Confidential information is not to be given verbally or in writing to anyone other than staff members who need such information to treat patient appropriately. I understand that when it is medically necessary to discuss confidential information, it should be done so in a private manner where others may not hear.

Information released to the public or news media is done so only with approval of administration and patient consent. Administrative approval will need to be sought from the Public Relations Director or Administrator.

I understand that when my business with Valley Health Page Memorial Hospital ceases, all information remains property of Valley Health Page Memorial Hospital and the patient and is to remain confidential.

I am aware that unauthorized release of confidential information may result in legal liability for myself and can immediately terminate what further business I have with Valley Health Page Memorial Hospital.

Signature____

Print Name____
Date____

For Internal Use Only

Application Received_________________________**Interview**___________________
Photo ID____________**Smock**___________ **Volunteer Handbook**___________
PPD (1st)___________**(2nd)**___________**Background Check**____________
VH Orientation____
PMH Orientation____
Health Practice Training____
Notes____
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