ValleyHealth
Warren Memorial Hospital

Volunteer Application

Name: ____ Date of Birth: ____________________

Address: ____

Telephone Number: ________________________ Email address: _______________________________

Emergency Contact: _____________________________ Relationship: ___________________________

Telephone Number: _____________________________ Address: _______________________________

Volunteer Experience: ____

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Work Experience: ____

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If you were born after 1957, have you been immunized against Measles, Mumps, and Rubella? If so, please list the dates of these vaccinations: ____

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Circle Days of Week Su M T W Th F Sa Circle Time Morning Afternoon Evening

What has motivated you to offer your services on a Volunteer basis to Warren Memorial Hospital? _________

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How did you learn about the volunteer program? If you were referred, who referred you? ________________

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By signing below, I do hereby affirm that all of the information listed above is true to best of my knowledge and I give Warren Memorial Hospital the right to check on my background and release from all liability or responsibility all person, companies, or corporations supplying this information.

Signature: ____ Date: _____________________________

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When you have completed the application you may turn it into the front desk at Warren Memorial Hospital or mail it to Warren Memorial Hospital 1000 North Shenandoah Avenue Front Royal, VA 22630. Someone from the Auxiliary will be in touch about your application.