APPLICATION FOR VOLUNTEER SERVICE

Highlands ARH Regional Medical Center

(To be completed by applicant)

Name: ____ **Birthdate:** _____________

Mailing Address: ____

City: __________________________________ **State:** ________ **Zip Code:** ___________

Home Phone: ____________ **Cell Phone:** ____________ **E-Mail:** ___________________

Preferred method of contact: ___ Phone ___ E-mail ___ Text **SS#:** ____________________

References: Please include name, relationship, and phone number of two personal references.

1. ____

2. ____

Volunteer Area(s) of Interest:

____

Please list the days of the week and times that you are available to volunteer:

____

Person to Contact in Case of Emergency:

Name: ______________________________________ **Phone:** ___________________________

By my signature below I certify that I am at least 18 years of age and in good physical and mental condition to serve as a volunteer. I agree to uphold the purpose and policies of the volunteer program of Appalachian Regional Healthcare.

Applicant Signature: _________________________________ **Date:** ____________________

Return Completed Application in person, by mail, or e-mail to:

Sabrina Blair
Highlands ARH Regional Medical Center
5000 KY Route 321
Prestonsburg, KY 41653
E-mail: sblair1@arh.org

Questions, please call: (606) 886-7606