LITTLETON REGIONAL HEALTHCARE
Where good health begins.

ADULT VOLUNTEER APPLICATION

Name: _____ Phone Number: ____-____-_____

Mailing Address: _____SS#:____-___-_____

City, State, Zip: _____/_____/_____

Email: _____Date of Birth: ___/___/_____

Why do you want to volunteer: _____

_____

How did you hear about our volunteer program? _____

Previous volunteer experience: _____

_____

Previous work experience: _____

_____

Name, relationship, and phone/email for two professional references (someone you have worked or volunteered with or for):

1)_____

2)_____

Limitations and/or accommodations needed: _____

_____

Emergency Contact Person: _____

Phone: _____Relationship to you: _____

What hobbies or special interests do you have?

_____

_____

More on back side.

Volunteer

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Please select areas you are interested in helping (select all that apply).

- ❑ Main Desk (near emergency department) – work as a team of two to greet patients and visitors, give directions, occasionally push a wheelchair.
- ❑ Same Day Surgery Check-In - greeting patients, bringing patients back to the same day surgery area, assisting surgical staff with patients.
- ❑ Medical Office Building - greeting patients and visitors, giving directions, in some cases pushing a wheelchair.
- ❑ Lower Atrium - greeting patients and providing directions to patients and visitors.
- ❑ Moose Ledge Gift Shop – Help customers, use computer/cash register for sales.
- ❑ Other, I would rather have a job that helps behind the scenes.

Please note: You may be asked to assist with mailings, folding and stuffing folders and/or clerical work while you are stationed at your desk assignment.

What day or days of the week are you available?

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Shift: ☐ 7 am – 10 am ☐ 10 am – 1 pm ☐ 1 pm – 4 pm ☐ 4 pm – 6 pm

By signing this application, I acknowledge that the application process also includes a background investigation including a criminal history check, as well as a physical assessment which includes a drug test and blood draw which will all be completed at the hospital's expense. I understand that at any time, certain vaccines and/or protections are a requirement of the hospital and if I do not have proof of these and choose to get these vaccines and/or protections, I will be required to submit an exemption to hospital administration.

Signature_____ Date_____

Please return completed application to:

Dawn Lambert
LRH Volunteer Services
Littleton Regional Healthcare
600 St. Johnsbury Road
Littleton, NH 03561
dlambert@lrhcares.org
(603) 444-9331

Volunteer