



# LEXINGTON MEDICAL CENTER

## Volunteer Services

Please complete this application if you are interested in becoming a Lexington Medical Center volunteer.

Lexington Medical Center is an equal opportunity employer and pledges to provide equal opportunities without regard to race, color, religion, age, sex, national origin, disability or veteran's status. Lexington Medical Center provides a smoke-free work environment.

2720 Sunset Blvd.  
West Columbia, SC 29169  
803.791.2573

### Adult Volunteer Program Application

#### Applicant Information

Full Name: \_\_\_\_\_ Date: \_\_\_\_\_  
*Last First M.I.*

Address: \_\_\_\_\_  
*Street Address Apartment/Unit #*

\_\_\_\_\_  
*City State ZIP Code*

Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

Availability:  
Morning: \_\_\_\_\_ Afternoon: \_\_\_\_\_ Evening: \_\_\_\_\_  
Weekends: \_\_\_\_\_

Volunteer Position Preference: \_\_\_\_\_

Please list any special skills, hobbies, and/or interests.  
\_\_\_\_\_

Why do you want to volunteer?  
\_\_\_\_\_

Have you been convicted of anything other than a minor traffic violation? YES NO

If yes, explain: \_\_\_\_\_

## Education

Highest Level of Education Completed: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_ Did you graduate? YES  NO  Diploma: \_\_\_\_\_

## Previous Employment and/or Volunteer Experience

Please list any professional and/or volunteer experience: \_\_\_\_\_

If currently employed, please list your employer: \_\_\_\_\_

Job Title: \_\_\_\_\_

Responsibilities: \_\_\_\_\_

May we contact your current supervisor for a reference? YES  NO

## References

*Please list two references. Relatives cannot be listed.*

Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Email: \_\_\_\_\_

Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Email: \_\_\_\_\_

## Physician

Personal Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

*Street Address*

*Apartment/Unit #*

*City*

*State*

*ZIP Code*

**Disclaimer and Signature**

*I certify that the information I have given on this application is true and complete and agree that any false information including that given at the time of physical examination is cause for dismissal. The company, schools and person named above may give information regarding me and I release them from all liability for doing so. I understand that any offer by the Volunteer Services Department is conditional on satisfactory replies from references, background check, health reference and physical examination, which includes blood and/or urine tests to detect the presence of illegal drugs or alcohol. This is not a contract for the Volunteer Services Department and Lexington Medical Center has the right to separate you from the volunteer program at any time as you have the right to leave at any time. If qualified for volunteer service, I agree to abide by the rules and regulations of Lexington Medical Center, the policies and procedures of the Volunteer Services Department and the department to which I am assigned. I will respect the confidentiality of patient information and abide by all HIPAA guidelines.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

You must volunteer a minimum of 50 hours during your duration as a volunteer. Documentation of hours will only be provided to those who complete 50 hours or more. It is the volunteer's responsibility to clock in and out each day.

\_\_\_\_\_ Initial