



Titusville Area Hospital

Volunteer Registration Form

(Auxiliary, Student/Intern, Foundation and Ministerium)

NOTE: Eighteen (18) years of age or older.

Date: _____

Name: _____
(Last) (Middle) (First)

Address: _____
(Street) (City) (Zip)

Phone: _____
(Home) (Work/Other)

Days Available: _____ Hours Available: _____

Please check the Volunteer position(s) you are interested in:

- Floor Service** (helps patients in the morning, providing water, deliver newspapers, and assist nurses by making charts).
- Escort Desk** (greet/direct people who enter the hospital, help discharge/escort patients to their vehicle, deliver cards and flowers)
- Snack Shop** (waitress, take and deliver orders, wash dishes)
- Assist with fundraisers.**

EMERGENCY CONTACT:

1. _____
(Name) (Relationship) (Phone)

2. _____
(Name) (Relationship) (Phone)

Do you have a sponsor or person recommending you? YES / NO (circle one)
(If so, please name) _____

Have you had any previous experience in a hospital setting? YES / NO (circle one)
If so, please explain: _____

Education/Training: Do you have any special training, hobbies or skills? _____

Do you have any physical limitations? _____ If so, please explain: _____

What other Volunteer/Service Organizations do you currently belong to? _____

Describe, briefly, your reasons for seeking a volunteer position at Titusville Area Hospital: _____

I understand that I am a volunteer, not a paid employee of Titusville Area Hospital Auxiliary. I further understand that a membership fee is required with the return of this completed form. (\$10.00 for active membership or \$15.00 for inactive membership)

During the time I am volunteering at Titusville Area Hospital, I understand that I must keep patient information strictly confidential. If I learn of certain information relating to patients, employees or other hospital related business, I will treat this information as confidential.

Confidentiality of patient information must be maintained, whether in written or verbal form. Patient related information is never to be discussed in lobby, hallways, elevators, snack shop or other areas where information may be overheard by other patients or visitors. All information concerning a patient, including the fact that he/she has ever been a patient at Titusville Area Hospital, shall remain confidential. It is your responsibility to refrain from and prevent the unauthorized disclosure of confidential information and to disclose information only to those individuals with a valid and authorized need.

Any volunteer may be asked to terminate service because of breach of patient confidentiality, unexplained absences or other unprofessional conduct.

I certify that all statements made by me on this application are true and complete. I authorize Titusville Area Hospital Auxiliary to inquire of references as to my qualifications and desirability as a volunteer. By signing below, I agree to abide by the policies and procedures of Titusville Area Hospital and the Titusville Area Hospital Auxiliary.

Signature: _____ Date: _____

Print Name: _____

Mail your completed form (and membership dues) to:	Titusville Area Hospital Auxiliary Membership Chairperson 406 West Oak Street, Titusville, PA 16354
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Once your registration form (and membership dues) are received, you will be contacted for orientation and training.

Office Use:

Orientation Date: _____ Specific Training Date (if required): _____

Starting Date: _____

Revised 1/10