

VOLUNTEER PROGRAM APPLICATION FORM

Return completed application to:
Volunteer Services
801 5th Street, Sioux City, IA 51101

Name: _____
Last
First
Middle Initial

Address: _____
Street
City
State
Zip Code

Telephone #: (____) _____ - _____ **Email Address:** _____

Are you 16 years old or older: ____ Yes ____ No

Please indicate type of volunteering activities you are interested in: (check all that apply)

Greeters (Reception / Waiting Room / Welcome Desk / Patient Transport)

Gift Shop Staff

Pastoral Ministry and Care

Clerical

Patient Well-being (sitting, visiting, walking)

NHS – Silver Cord Program

Please indicate below the days and hours available to volunteer

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning							
Afternoon							
Evening							

Signature of Applicant: _____ **Date:** _____

TO BE COMPLETED BY VOLUNTEER SERVICES PERSONNEL:	
Date application received in Volunteer Services:	Date of Initial Contact: _____ Contacted by: _____
Interview Date Scheduled: _____ Time: _____	Volunteer Accepted: Yes No If No, reason _____