



## Adult Volunteer Application

*Volunteer Services Mission Statement:  
Volunteer Services is dedicated to provide the highest  
quality of volunteer support to those we serve within the  
regional Health System.*

**Please mail to:**  
St. Mary's Medical Center  
Volunteer Services  
407 East Third Street  
Duluth MN 55805  
(218) 786-4420

**Please advise us if any accommodation is needed to participate in the application process.**

**Date:** \_\_\_\_\_

**Are you required to volunteer?**    No    Yes - by whom? \_\_\_\_\_

Last Name	First Name	MI	Nickname
Complete Address	City	State	Zip
Email	Home Phone	Cell Phone	

### EMERGENCY CONTACT

Name	Relationship	Day Time Phone
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### EDUCATION AND WORK EXPERIENCE

Current Employer	Circle Current Grade    8 9 10 11 12 13 14 15 16
Work Phone	Current School/College
Position Responsibilities	Graduation Date
Have you ever been employed with SMDC Health System? Yes <input type="checkbox"/> No <input type="checkbox"/> From _____ To _____ (Month/Yr)	
Facility/Department:	Your Name at the time:

**At which campus do you want to volunteer**

<input type="checkbox"/> St. Mary's Duluth	<input type="checkbox"/> Duluth Clinic	<input type="checkbox"/> SMDC Medical Center <small>(Miller Dwan Bldg.)</small>	<input type="checkbox"/> St. Mary's Superior
<input type="checkbox"/> Hermantown	<input type="checkbox"/> East Range	<input type="checkbox"/> Itasca	<input type="checkbox"/> Undecided

Skills/Preference	Volunteer Work Preference	Availability							
<input type="checkbox"/> Helping/Interacting Visitors	<input type="checkbox"/> Adults	Please check the boxes for the days and times you are most often available to volunteer.							
<input type="checkbox"/> Helping/Interacting Patients /Staff	<input type="checkbox"/> Children								
<input type="checkbox"/> Mailings/Special Projects	<input type="checkbox"/> Visitors/Families								
<input type="checkbox"/> Filing/Copying	<input type="checkbox"/> Patients								
<input type="checkbox"/> Errands/Delivery	<input type="checkbox"/> Hospice		S	M	T	W	TH	F	S
<input type="checkbox"/> Answering Phones	<input type="checkbox"/> Grief Support	Morning							
<input type="checkbox"/> Data Entry	<input type="checkbox"/> Other Volunteers	Afternoon							
<input type="checkbox"/> Word Processing	<input type="checkbox"/> Office	Evening							
<input type="checkbox"/> Patient Packets	<input type="checkbox"/> Numbers/Data	Are you willing to make a commitment to volunteer at a regular scheduled time?							
		<input type="checkbox"/> Yes <input type="checkbox"/> No							

How did you hear about volunteering? \_\_\_\_\_

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

REFERENCES – DO NOT LIST RELATIVES

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1	Name	Day Time Phone
Complete Address		City
		State/Zip
2	Name	Day Time Phone
Complete Address		City
		State/Zip

I hereby authorize investigation of all statements contained in this application. I further authorize my reference permission to furnish SMDC Health System with facts and opinions as to my job performance, capabilities and desirability as a volunteer. I further release all persons whomsoever from any damage because of furnishing said information.

The information in this application is accurate and correct to the best of my knowledge.

I agree as a volunteer my time and talents will be given freely without any expectation of monetary reimbursement.

I am participating in a community program, which reimburses me for volunteer service hours.

Your Signature \_\_\_\_\_ Date \_\_\_\_\_

**Volunteer opportunities are provided without regard to religion, creed, race, national origin, sexual orientation, age, gender, disability, marital status or status with regard to public assistance. SMDC does not imply that you will be assigned a volunteer position and this application should not be construed as a contract or promise of a volunteer position.**