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**VOLUNTEER APPLICATION
PATIENT & FAMILY ADVISORY COUNCIL (PFAC)**

**Please print or type clearly*

Name (*first and last*):

Application Date:

Volunteer Position Sought:

Patient and Family Advisory Council Member

Home Address:

Home/Cell Phone

Employment

Current Employer, if applicable:

Position/Title:

Address:

Employer Phone Number:

Would you like us to keep your employer abreast of your volunteer service and achievement?

No Yes

About You

Please list your involvement with community groups, clubs, & organizations, if any:

Please describe any prior volunteer experience, if applicable (include organization names and dates of service):

What experiences have you had that may help prepare you to work as a volunteer on the Patient & Family Advisory Council for Community Hospital? *(i.e., hospital system patient, family of patient, community member with interest in helping, former positive experience, former negative experience...)*

Why do you want to volunteer? What do you want to gain from this experience?

Have you ever been convicted of a crime? *[If yes, please explain the nature of the crime and the date of the conviction and disposition.] Conviction of a crime is not an automatic disqualification for volunteer work.*

References: *Please list three people who know you well and can attest to your character, skills and dependability (NOT family members). You may include your current or last employer:*

Name/Organization	Relationship to You	Phone

Please read the following carefully before signing this application:

I understand that this is an application for and not a commitment or promise of volunteer opportunity.

I certify that I have and will provide information throughout the selection process, including on this application for a volunteer position and in interviews with Community Hospital that is true, correct and complete to the best of my knowledge. I certify that I have and will answer all questions to the best of my ability and that I have not and will not withhold any information that would unfavorably affect my application for a volunteer position. I understand that information contained on my application will be verified by Community Hospital. I understand that misrepresentations or omissions may be cause for my immediate rejection as an applicant for a volunteer position with Community Hospital or my termination as a volunteer.

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Signature or Electronic Signature

Date