



**APPLICATION FOR MEMBERSHIP**

Please print and fill out this form and mail, fax, or deliver to:  
 Volunteer Services, Santa Barbara Cottage Hospital  
 Pueblo and Bath Streets, PO Box 689  
 Santa Barbara CA 93102  
 805/569-7357 Fax 805/682-8423

Date \_\_\_\_\_

|                    |              |   |                     |
|--------------------|--------------|---|---------------------|
| Mr./Mrs./Ms.       | Last Name    | First Name  | Spouse's First Name |
| Address            |              |   |                     |
| City               |              | ZIP Code  |                     |
| (      )           |              |   |                     |
| Telephone          |              | E-mail  |                     |
| ____ / ____ / ____ |              | <input type="checkbox"/> M <input type="checkbox"/> F |                     |
| Date of Birth      |              | Gender  |                     |
| Emergency contact  |              | (      )  |                     |
|                    |              | Phone   |                     |
| REFERENCES         |              |   |                     |
| Name               | Relationship | Telephone   |                     |
|                    |              | (      )  |                     |
|                    |              | (      )  |                     |
|                    |              | (      )  |                     |
|                    |              | (      )  |                     |

| Please mark the times you are available to volunteer |     |     |     |     |     |     |     |
|--|-----|-----|-----|-----|-----|-----|-----|
| Approximate Times                                    | SUN | MON | TUE | WED | THU | FRI | SAT |
| 8 am-12 pm   |     |     |     |     |     |     |     |
| 12 pm-4 pm   |     |     |     |     |     |     |     |
| 4 pm-8 pm  |     |     |     |     |     |     |     |
| 8 pm-12 am   |     |     |     |     |     |     |     |

**Please check the area(s) that interest you**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Admitting Charts            | <input type="checkbox"/> Junior Wheelchair          | <input type="checkbox"/> Patient Transport              |
| <input type="checkbox"/> Ambassadors                 | <input type="checkbox"/> Camp (summer only)         | <input type="checkbox"/> Patient Visitor Services (18+) |
| <input type="checkbox"/> Birth Center (18+)          | <input type="checkbox"/> Laboratory                 | <input type="checkbox"/> Pediatrics (18+)               |
| <input type="checkbox"/> Caring Hands (Sewing)       | <input type="checkbox"/> Library (Medical) (18+)    | <input type="checkbox"/> Pet-Assisted Therapy           |
| <input type="checkbox"/> Clerical                    | <input type="checkbox"/> Library (Patients)         | <input type="checkbox"/> Pre-Surgical (18+)             |
| <input type="checkbox"/> Cottage Rehab Hospital      | <input type="checkbox"/> Lifeline Services (18+)    | <input type="checkbox"/> Project Linus                  |
| <input type="checkbox"/> Docent                      | <input type="checkbox"/> Loading Dock (18+)         | <input type="checkbox"/> Pharmacy Delivery (18+)        |
| <input type="checkbox"/> Emergency Department        | <input type="checkbox"/> Medical ICU (18+)          | <input type="checkbox"/> Surgery Information (18+)      |
| <input type="checkbox"/> Eye Center Greeter          | <input type="checkbox"/> Mother/Infant Unit (18+)   | <input type="checkbox"/> Surgical ICU (18+)             |
| <input type="checkbox"/> Gift Shop (18+)             | <input type="checkbox"/> NICU (Neonatal Unit) (18+) | <input type="checkbox"/> Tray Favors                    |
| <input type="checkbox"/> Information Desk            | <input type="checkbox"/> Newsletter                 | <input type="checkbox"/> Unit Volunteer                 |
| <input type="checkbox"/> Interpreting Services (18+) | <input type="checkbox"/> Outpatient Surgery Greeter |   |

What is your first area of interest? \_\_\_\_\_

What is your second area of interest? \_\_\_\_\_

What is your third area of interest? \_\_\_\_\_

Foreign language skills \_\_\_\_\_

Other skills, education, or special training \_\_\_\_\_

Are you currently employed?  Yes  No If so, where \_\_\_\_\_

Are you attending school?  Yes  No If so, where \_\_\_\_\_

**Office / Technical Skills**

- Accounting
- Computer knowledge:
  - Excel
  - Word
  - PowerPoint
- Filing
- Typing WPM: \_\_\_\_\_
- Office Equipment (10-key)
- Cashier / Sale
- Telephones

**Creative Skills**

- Humor / Stories
- Board and Card Games
- Musical Instrument
- Singing
- Sewing / Needlepoint
- Knitting
- Drawing / Painting

**Creative Skills**

- Customer Service
- Food Service
- Mail Room
- Reception Desk
- Photography
- Other:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you volunteered at Cottage Health System before?  Yes  No

If so, why did you leave? \_\_\_\_\_

I am interested in volunteering for the following reason(s): \_\_\_\_\_

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

Have you been convicted of a misdemeanor or felony, or are there pending criminal charges against you? Please do not list any marijuana-related conviction more than two years old, any conviction that is "sealed" or "expunged", or referral to any diversion program. Please do list all other convictions, including driving under the influence. Provide a full explanation of the conviction or pending criminal charges. A conviction or pending charges will not necessarily disqualify you from volunteering. Each situation will be considered on its own merits. Falsifying your application by failing to disclose relevant information in response to this question, however, will disqualify you from volunteering.

Yes  No If Yes, please list / describe: \_\_\_\_\_

Do you have any medical conditions that will limit your ability to function as a volunteer?  Yes  No

If so, are there ways in which your volunteer duties will have to be modified to accommodate your medical condition? Please explain. NOTE: *You are not required to disclose the nature of your medical condition in response to this question.* \_\_\_\_\_

I understand and agree that in performing my service as a volunteer of SBCH I must hold patient and other confidential information in confidence. I understand that any violation would be grounds for disciplinary action.

I am volunteering my services to Santa Barbara Cottage Hospital solely for my personal purposes or benefit without promise or expectation of compensation or benefits. I agree to serve as a volunteer for a 6-month commitment for 100 cumulative hours of service.

I declare that all of the statements in this application are true, correct, and complete to the best of my knowledge and authorize Cottage Health System to investigate any statements in determining my eligibility for a volunteer position. I understand that falsification or material omission on this application is grounds for rejection of my application or my dismissal from volunteering. I acknowledge that the continuation of my volunteer position is at the consent of the volunteer and the hospital. This volunteer position is terminable at will by either party.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_