THE University of Vermont HEALTH NETWORK
Porter Medical Center

VOLUNTEER APPLICATION Date: _____

(for new or returning volunteers)

NAME: _____ pronouns: _____
Last First

DOB: _____ *PHONE*: (h) _____ (c) _____

E-MAIL: _____

ADDRESS: _____TOWN: _____ STATE:____ ZIP:_____

EMERGENCY CONTACT: _____ Relationship:_____
Last First

PHONE: (h) _____ (c) _____

Please note:

Volunteers are required to have the following: *(NOT REQUIRED FOR VOLUNTEERS AT ROUND ROBIN RESALE STORE)*

- Proof of COVID vaccination – completed initial series (Pfizer 2 doses, Moderna 2 doses, Johnson & Johnson 1 dose)
- Proof of Flu Vaccine (annually) – free at PMC (or sign waiver and masking required)
- TB blood test (for Tuberculosis) – free at PMC lab (with provided form)

Volunteers must consent to allowing Porter Medical Center to conduct criminal background checks

Volunteers are required to review an online Volunteer Orientation which will be emailed to you once the above are received

Where do you want to volunteer? ☐ Porter Medical Center ☐ Helen Porter Rehab Center (addt'l health screening required)

☐ End of Life Services ☐ Patient Family Centered Care (page 3 info sheet required) ☐ Round Robin Resale Store

What type of volunteer work are you interested in doing here? _____

_____

Name: _____
Last First

How did you learn about Volunteer opportunities at Porter Medical Center? _____

_____

Have you ever worked at Porter Medical Center or volunteered here before? ☐ YES ☐ NO

If yes, tell us more: _____

_____

Please tell us about any previous volunteer work you have done: _____

_____

Please tell us about your interests/skills/hobbies: _____

_____

What days and times are you available to volunteer? _____

The Volunteer Service Department is not obligated to provide a placement, nor are you obligated to accept a position offered. Opportunities for volunteers are provided without regard to race, color, national origin, disability or age.

CAREFULLY READ THIS SECTION PRIOR TO PROVIDING SIGNATURE BELOW

I hereby affirm that the information provided on this application is true and complete.
Your signature indicates your consent for Porter Medical Center to conduct criminal background and adult protective services checks.

Signature: _____ Date: _____