



# SCHOOLCRAFT MEMORIAL HOSPITAL

7870W US Hwy 2  
Manistique, MI 49854

## VOLUNTEER APPLICATION

Schoolcraft Memorial Hospital is an Equal Opportunity Employer. It is our policy to hire the best qualified applicants. We do not discriminate on the basis of race, color, creed, religion, national origin, sex, disability or handicap, age, height, weight, veteran status, marital status, or any other reason prohibited by law.

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NAME: Last First Middle Initial

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ADDRESS: Street City State Zip

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E-MAIL: Home Phone Work Phone Cell Phone

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VOLUNTEER POSITION(S) DESIRED: \_\_\_\_\_

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LIST ANY SPECIALIZED TRAINING OR EXPERIENCE YOU MAY HAVE FOR THIS POSITION:  
(FORMAL EDUCATION IS SHOWN ON NEXT PAGE) \_\_\_\_\_

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CURRENT EMPLOYER: \_\_\_\_\_ PHONE #: \_\_\_\_\_

PROFESSIONAL LICENSE NUMBER (IF APPLICABLE): \_\_\_\_\_

PLEASE LIST TYPE OF LICENSE: \_\_\_\_\_

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WHY DO YOU CHOOSE VOLUNTEER WORK? \_\_\_\_\_

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PRIOR VOLUNTEER EXPERIENCE: \_\_\_\_\_

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HAVE YOU EVER BEEN CONVICTED OF A FELONY? \_\_\_\_\_

HAVE YOU EVER BEEN CONVICTED OF A MISDEMEANOR? \_\_\_\_\_

EDUCATION:					
Name & Address of Schools or Colleges	Major Subject	Did you Graduate?	College Degree	Years of Attendance	
				From	To

BUSINESS REFERENCES		
Name	Address	Phone

EMERGENCY CONTACT NAME: \_\_\_\_\_

EMERGENCY CONTACT PHONE NUMBER: \_\_\_\_\_

I understand that this application is not an offer of employment. I agree that my volunteer work at Schoolcraft Memorial Hospital that my employment may be terminated at any time, with or without notice & with or without cause, at the option of either the Hospital or myself.

I understand that I will be subject to the policies and rules and regulations established by the Board of Trustees and the Administrator and that these policies, benefits, rules and regulations are subject to change by the Board of Trustees and the Administrator at any time.

I understand that any misstatements in, or omissions from this application constitute cause for denial of volunteer work or cause for dismissal. All information submitted by me in this application is true to the best of my knowledge and belief.

I authorize the references listed in this volunteer application and any prior employer, educational institution, or any other persons or organizations to give Schoolcraft Memorial Hospital any and all information concerning my previous employment/educational

accomplishments, disciplinary information, or any other pertinent information they may have. I understand that such information may contain my social security number. I release all parties from all liability for any damage that may result from furnishing that information to this hospital. In addition, I hereby waive written notice that employment information is being provided by any person or organization.

This application is current for a period of six months. At the conclusion of this time, if I have not heard from the employer and still wish to be considered as a volunteer, it will be necessary to fill out a new application.

Signature of Applicant: \_\_\_\_\_ DATE: \_\_\_\_\_

Please Print Name: \_\_\_\_\_

If you have any questions, or would like to update your application at any time in the future, please contact Fawn Freeborn, Human Resources Generalist, at 341-1881.  
Thank you.