Community Memorial Hospital
Volunteer Services Organization
512 Skyline Blvd.
Cloquet, Minnesota 55720
218-879-4641 X7142

Thanks so much for your interest in being a volunteer here at Community Memorial Hospital. Our volunteers are a very important part of our service. We appreciate the opportunity to include you, as we do our best to meet the medical needs of people in our community.

There are a few steps to take before getting you on the volunteer roster. Please return your papers by mail or bring them directly to the Volunteer Office on 1st floor by the Gift Shop when you are in the building.

_____ Interview with Deanna Call 879-4641 x7142 for appt.

_____ Welcome Day/HIPPA Video

_____ Flu Shot Form Signed

_____ Background Study/Fingerprinting

Thanks again for being willing to go through the Volunteer Orientation process. We hope to make a good match for your interests and availability. Please stay in touch and don't hesitate to call if you have questions or wish to speed the above process along.

We look forward to having you as a regular member of our team.

Sincerely,

Deanna Johnson
CMH Volunteer Coordinator

Application to Volunteer at CMH

Please Print Name_____
(Last) (First) (Middle)
Address_____
City_____State_____Zip_____
Phone
Home_____
Work_____
Cell_____
E-Mail Address_____

Date of Birth_____

When is the best time of day to contact you?_____

When would you like to volunteer?

Frequency_____
Day (s) of week_____
Time of day_____
Length of day_____

What would you prefer to do while volunteering?_____
_____
_____
_____

Signature_____Date_____

Return this in person or by mail to
Deanna Johnson, Community Memorial Hospital
512 Skyline Boulevard, Cloquet, MN. 55720

Or fax to 218-879-9167, Attn: Volunteer Office

CMH Community Memorial Hospital

BACKGROUND STUDY FORM

Please print clearly. Items marked with an asterisk (*) are required. All other information is optional

* First Name: _____

*Middle Name: _____

*Last Name: _____

Suffix: _____

*Social Security Number: _____

*Date of Birth: _____

*Race: _____

*Sex: ☐ Male ☐ Female ☐ Other

*Eye color: _____

*Hair color: _____

*Height: _____

*Weight: _____

*US Citizen ☐ **Yes** ☐**No**

*Place of Birth (if US, state only; if outside US, name of country) _____

Permanent/Physical Address

*Address Line 1: _____

Address Line 2: _____

*City: _____

*State & Zip: _____

County _____

Mailing Address

☐ **Check if same as permanent address, if not fill out address below.**

*Address Line 1: _____

Address Line 2: _____

*City: _____

*State & Zip: _____

County _____

*Drivers License/ID #: _____

*Drivers License/ID State: _____

*Drivers License/ID Expiration: _____

*Primary Phone: _____

*Primary Phone Type: ☐ Mobile ☐ Landline ☐ Other

*Email Address: _____

***Other Last Names Used (such as maiden name)**

Last Name: _____

Last Name: _____

Last Name: _____

***Other First Names Used**

First Name: _____

First Name: _____

***Lived out of state in past 5 years?** ☐ **Yes** ☐ **No** **If yes, fill out information on the reverse side of this form.**

By signing below the prospective employee/volunteer/intern consents to allow Community Memorial Hospital to conduct a backgrouond study in accordance with CMH Backgrouond Study Policy and MN State Statute 245C.03. Your privacy rights are outlined on the attached form. It is also available from CMH's Human Resources Department or the MN Department of Human Services by calling 651.296.3971 (voice) or 651.292.6832 (TTY).

Signature **Printed Name** **Date**

Yes, I have lived out of the state of Minnesota at the location(s) listed below in the past 5 years.

*City: _____

*State & Zip: _____

*Year from: _____

*Year to: _____

*City: _____

*State & Zip: _____

*Year from: _____

*Year to: _____

*City: _____

*State & Zip: _____

*Year from: _____

*Year to: _____

*City: _____

*State & Zip: _____

*Year from: _____

*Year to: _____