



Volunteer Patient and Family Advisor Application

Date _____

Personal Information

Name _____

Address _____

City _____ State _____ Zip _____

Primary Phone # _____ Cell Phone # _____

E-mail Address _____

Emergency Contact _____ Relationship _____

Home Phone # _____ Work Phone # _____

Do you speak another language? Yes No If yes, please list _____

Are you: Patient Family Member of a Patient

Definition of Family Member: A family member may or may not be related to the patient, can change according to care situations and is defined by the patient.

Advisor Information

When would you be able to attend meetings/events? *(Please give specific days and times)*

What times are you able to attend meetings/events? Mornings Afternoons Evenings Weekends

What days of the week are best for you? Monday Tuesday Wednesday Thursday Friday

Please choose all of the facilities you are interested in:

North Mississippi Medical Center-Baldwyn Nursing Facility

North Mississippi Medical Center-Eupora

North Mississippi Medical Center-Hamilton

North Mississippi Medical Center-Iuka

North Mississippi Medical Center-Pontotoc

North Mississippi Medical Center-Tupelo

North Mississippi Medical Center-West Point

Have you ever worked or volunteered at NMMC before? Yes No

Background Information

Have you ever been convicted or plead guilty to a crime? Yes No If yes, please explain _____

References

Please list three (3) references not related to you: (complete mailing addresses are required)

Name _____ Phone # _____ Email _____

Relationship: Business Personal Years Acquainted _____

Address _____ City _____ State _____ Zip _____

Name _____ Phone # _____ Email _____

Relationship: Business Personal Years Acquainted _____

Address _____ City _____ State _____ Zip _____

Name _____ Phone # _____ Email _____

Relationship: Business Personal Years Acquainted _____

Address _____ City _____ State _____ Zip _____

I authorize NMMC/NMHS to check the listed references and verify the information contained in this application, and I hereby release all references from all liability for issuing information regarding this applicant. I also understand that I will be required to submit to a background check, TB skin test and produce a childhood immunization record if born in 1957 or after, or submit to immunizations, as regulated by NMMC and CDC policies. If accepted as a volunteer at NMMC/NMHS, I understand that I am subject to removal if any of the information on this application is false or has been omitted, and that I may be asked to furnish documents supporting the statements herein.

Applicant Signature _____ Date _____

**PLEASE MAIL APPLICATION TO:
North Mississippi Medical Center
Volunteer Services Department
830 South Gloster Street
Tupelo, Mississippi 38801
(662) 377-3131**

North Mississippi Health Services does not discriminate based on national origin, age, race, sex, religion, covered disabilities and other protected status. These are not factors considered for volunteerism at North Mississippi Health Services.

FOR OFFICIAL USE ONLY

Interview _____ Orientation _____ Background Check _____ Reference Check _____ Employee Health _____
CPR Certification _____ Volunteer Area _____ Days/Hours _____