

Fairview Park Hospital Chaplain Program
200 Industrial Blvd.
P.O. Box 1408
Dublin, Georgia 31021
(478) 274-3640

Application for Volunteer Hospital Chaplain Program

Date: _____ Social Security #: _____

Applicant's Full Name: _____
Last (Maiden, and all other) First Middle

Date of Birth: _____ Driver's License #: _____ State: _____ Exp: _____

Address: _____

_____ City State Zip Code

Home Phone: (____) _____ Cell Phone: (____) _____

Are you presently employed. If so where at? _____ Work Phone: (____) _____

Have you ever served as a Hospital Chaplain? _____ YES _____ NO

If YES, Where have you served? _____ How long did you serve? _____

When are you available to start as a Chaplain: _____

Please list any health problems that may limit you from performing your duties here at Fairview Park Hospital.

Do you have any Drug Allergies? _____

Physician _____ Physician Phone _____

Person to contact incase of emergency: _____
Name

Address Phone Number

Professional References(other than relatives). Please list three individuals who can attest to your character and dependability.

Name _____ Phone () _____
Address _____
City, State, Zip _____ Number of Years Known _____

Name _____ Phone () _____
Address _____
City, State, Zip _____ Number of Years Known _____

Name _____ Phone () _____
Address _____
City, State, Zip _____ Number of Years Known _____

How did you hear about the Fairview Park Hospital Chaplain Program? _____

** It is the policy of this organization to provide equal opportunity to persons regardless of race, religion, age, gender, disability or any other classification in accordance with federal, state, and local statutes, regulations and ordinances.

Office Use Only

Application reviewed by: _____ Date of PPD _____ HIPAA _____
Date of Orientation: _____ Code of Conduct Training _____