



VOLUNTEER SERVICES
HARRINGTON HEALTHCARE SYSTEM
100 SOUTH STREET
SOUTHBRIDGE, MA 01550

Date: _____

Date of Birth: _____

Last Name: _____ First Name: _____

Mailing Address:

Street: _____ City: _____ State: _____ Zip: _____

Telephone: Home: _____ Cell: _____

E-mail Address: _____ @ _____

Present Occupation: _____ Work #: _____

Person to contact in case of emergency:

Name: _____

Relationship: _____

Address: _____

Telephone (Home): _____

(Work): _____

(Cell): _____

Work Availability:

Weekdays/Days: _____

Evenings: _____

Weekends/Days: _____

Evenings: _____

Location: Check Mark Location of Interest:

Harrington Main Campus Harrington 61 Pine/G.B. Wells Harrington Healthcare at Hubbard
 The Cancer Center at Harrington Harrington Healthcare at Charlton

Foreign language(s) spoken fluently: _____

Areas of interest: 1. _____ 2. _____ 3. _____

References: For Example: Adult Friends, Clergy, Teacher, Supervisor, or Coach. No Relatives maybe used as a reference.

1. Name: _____ Telephone: _____

Address: _____

2. Name: _____ Telephone: _____

Address: _____

Volunteer Services complies with all state and local regulations and meets requirements of the Joint Commission on Accreditation of Healthcare Organizations.

Applicant Signature: _____

**CRIMINAL OFFENDER RECORD INFORMATION (CORI)
ACKNOWLEDGEMENT FORM**

HARRINGTON MEMORIAL HOSPITAL is registered under the provisions of M.G.L. c. 6, section 172 to receive CORI for the purpose of screening current and otherwise prospective employees, subcontractors, volunteers, license applicants, current licensees.

As a prospective or current employee, subcontractor, volunteer, license applicant, current licensee, I understand that a CORI check will be submitted for my personal information to the Department of Criminal Justice Information Services (DCJIS). I hereby acknowledge and provide permission to **HARRINGTON MEMORIAL HOSPITAL** to submit a CORI check for my information to DCJIS. This authorization is valid for one year from date of my signature. I may withdraw this authorization at any time by providing **HARRINGTON MEMORIAL HOSPITAL** with written notice of my intent to withdraw consent to a CORI check.

FOR EMPLOYEMENT, VOLUNTEER, AND LICENSING PURPOSES ONLY: **HARRINGTON MEMORIAL HOSPITAL**, may conduct subsequent CORI checks within one year of the date of this Form was signed by me provided, however, that **HARRINGTON MEMORIAL HOSPITAL** must first provide me with written notice of this check.

By signing below, I provide my consent to a CORI check and acknowledge that the information provided on Page 2 of this Acknowledgement Form is true and accurate.

Signature

Printed Name

Date: _____



SUBJECT INFORMATION:

LAST NAME FIRST NAME MIDDLE NAME SUFFIX

MAIDEN NAME (OR OTHER NAME(S) BY WHICH YOU HAVE BEEN KNOWN)

DATE OF BIRTH PLACE OF BIRFTH

LAST SIX DIGITS OF YOUR SOCIAL SECURITY NUMBER: -

SEX: HEIGHT: FT. IN. EYE COLOR RACE:

DRIVER'S LICENSE OR ID NUMBER: STATE OF ISSUE:

MOTHER'S FULL MAIDEN NAME FATHER'S FULL NAME

CURRENT AND FORMER ADDRESSES:

Street Number & Name City/Town State Zip

Street Number & Name City/Town State Zip

The above information was verified by reviewing the following form(s) of government issued identification:

Two blank lines for listing government issued identification forms.

VERIFIED BY: Name of Verifying Employee (please print) Signature of Verifying Employee

Two blank lines for the Name of Verifying Employee and Signature of Verifying Employee.