

Application for Volunteer Service

Volunteer Agreement and Certification of Information

As a volunteer of the Guam Regional Medical City, I agree:

To hold as absolutely confidential all information which I may obtain directly or indirectly concerning patients, parents, doctors, or personnel , and will not seek confidential information in regard to a patient.

That my services are donated to the Guam Regional Medical City without contemplation of compensation, or future employment, and given with humanitarian or charitable reasons.

I certify that the answers given by me to the foregoing questions and statements are true, correct, and without omissions. I authorize the Guam Regional Medical City to investigate and/ or verify the foregoing information and any other information, which might assist them in determining my qualifications for volunteering. I release the Guam Regional Medical City from any liability from damage, which may result from such investigation, if, upon investigation, anything contained in this application is found to be untrue. I further agree to conform to the rules and regulations of this facility. I understand that my volunteer status at the Guam Regional Medical City can be terminated at any time for failure to comply with the policies, rules, and regulations of the Hospital including those of the departments assigned to me; for absences without notification; for reasons of unsatisfactory attitude, work or appearance; and for any other circumstances which, in the judgment of the Hospital, would make my continued service as a volunteer contrary to the best interests of the Hospital. I also understand that no one has any authority to enter into any agreement for employment for any specified period of time or to make any agreement contrary to the foregoing, except for a written employment agreement signed by an administrative representative of this facility.

ANY PERSON WHO INTENTIONALLY GIVES MISLEADING OR FALSE
INFORMATION WILL BE SUBJECT TO IMMEDIATE TERMINATION.

Print Name: _____ Date: _____

Signature: _____

Please return the completed application by email or mail to:

info.grmc@grmc.gu

or

**Guam Regional Medical City
PO BOX 3830
Hagatña, Guam 96932**