



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: \_\_\_\_\_

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

**Applicant Signature:** \_\_\_\_\_





AGENCY CODE: HARMH
FEE CODE: EOHSS \$

CORI REQUEST FORM

Harrington Memorial Hospital has been certified by the Criminal History Systems Board for access to conviction and pending criminal case data. As an applicant / employee for the position of \_\_\_\_\_, I understand that a criminal record check will be conducted for conviction and pending criminal case information only and that it will not necessarily disqualify me. The information below is correct to the best of my knowledge.

APPLICANT / EMPLOYEE SIGNATURE

LAST NAME FIRST NAME MIDDLE NAME

MAIDEN NAME OR ALIAS (IF APPLICABLE) PLACE OF BIRTH

DATE OF BIRTH SOCIAL SECURITY NUMBER (Requested, but not required) ID Theft Index PIN (If applicable)

MOTHER'S MAIDEN NAME

CURRENT AND FORMER ADDRESSES:

SEX: HEIGHT: FT IN WEIGHT: EYE COLOR:

STATE DRIVER'S LICENSE NUMBER: (include state of issue)

\*\*\*\*\* THE ABOVE INFORMATION WAS VERIFIED BY REVIEWING THE FOLLOWING FORM OF GOVERNMENT ISSUED PHOTOGRAPHIC IDENTIFICATION:

REQUESTED BY: [Signature] SIGNATURE OF CORI AUTHORIZED EMPLOYEE

The CHSB Identity Theft Index PIN Number is to be completed by those applicants that have been issued an Identity Theft Index PIN Number by the CHSB. Certified agencies are required to provide all applicants the opportunity to include this information to ensure the accuracy of the CORI request process. All CORI request forms that include this field are required to be submitted to the CHSB via mail or by fax to 617-660-4614

RETURN TO: DEPT. OF PUBLIC SAFETY, HARRINGTON MEMORIAL HOSPITAL