



Garrett County Memorial Hospital Chaplaincy Program Application

Name: _____

Address: _____

Phone: (office) _____ (Home) _____

Education / Degrees: _____

Present Position: _____

Name of Church(es): _____

Where Are Your Ecclesiastical Credentials Held? (*Denomination or Judiciary*): _____

Date of Ordination: _____

Denomination: _____

Prior Chaplaincy Experience: _____

Clinical Pastoral Training? Yes _____ No _____

I hereby agree to follow the regulations and policies of the Chaplaincy Service set forth in its by laws.

(Signature)

(Date)

Confidentiality Pledge

I understand and agree that any information which I acquire in the performance of my duties as a volunteer of the Garrett County Memorial Hospital Chaplaincy program must be held in strict confidentiality. This includes patient, family, employee and physician information. I further understand that any violation of the confidentiality policy will result in my termination as a volunteer.

Signature: _____ Date: _____

Compliance Pledge

I agree to comply with and abide by the rules and regulations of the Garrett county Memorial Hospital and the department in which I volunteer. I understand that any infraction of the rules and regulations may result in my termination as a volunteer.

Signature: _____ Date: _____