Regional Medical Center

REFERENCE FORM | *Volunteer Application*

TO: _____
_____
_____

PHONE: _____

FROM: Valerie Lindsay
Volunteer Services & Fund Development Manager
Regional Medical Center
709 W Main St, PO Box 359
Manchester, IA 52057

Phone: 563-927-7534
Email: vlindsay@regmedctr.org

TO BE FILLED OUT BY APPLICANT

_____

Last Name Middle Initial First Name

The above named applicant authorizes the individual to furnish Regional Medical Center the information requested on this form.

_____

Signature of Applicant

_____

Date

Personal

Relationship to Applicant: _____ How long have you known the applicant? _____

Please check which best describes the applicant.

	Above Average	Average	Below Average	Unsatisfactory
Quality of Work	☐	☐	☐	☐
Quantity of Work	☐	☐	☐	☐
Dependability	☐	☐	☐	☐
Attendance & Punctuality	☐	☐	☐	☐
Cooperation & Flexibility	☐	☐	☐	☐
Attitude	☐	☐	☐	☐
Initiative	☐	☐	☐	☐
Ability to work with others	☐	☐	☐	☐

Comments: _____

Title:_____

Signature: _____ Date:_____

Please email completed form to vlindsay@regmedctr.org or mail to: ATTN Valerie Lindsay, Regional Medical Center, PO Box 359, Manchester, IA 52057