Your Hospital's Logo Here

VOLUNTEER SERVICE APPLICATION

INTERNAL USE ONLY

DATE APPLICATION RECEIVED ______ SCHEDULED INTERVIEW DATE ______ SCHEDULED ORIENTATION DATE ______

SERVICE AREA (S) ______ SCHEDULED DAY(S) & HOURS ______

VOLUNTEER SERVICES
Street Address
City, State Zip

Hospital Tel: (202) 555 - 1212
Long Term Care Tel: (202) 555 - 1212

PERSONAL INFORMATION

NAME: (First) (Middle) (Last) DATE:

ADDRESS: (Number & Street) (Apartment Number)

(City) (State) (Zip)

SOCIAL SECURITY #: DATE OF BIRTH: E-MAIL ADDRESS:

TELEPHONE DAYS : (Area Code) TELEPHONE EVENINGS: (Area Code)

EDUCATION: ☐ CURRENTLY A STUDENT *If "YES" > >* (School Name) ______ (Location) ______

☐ FRESHMAN ☐ SOPHOMORE ☐ JUNIOR ☐ SENIOR ☐ Full Time ☐ Part Time

EDUCATION COMPLETED:

	SCHOOL NAME	**DEGREE / MAJOR**
☐ HIGH SCHOOL		
☐ SOME COLLEGE		
☐ COLLEGE		
☐ GRADUATE SCHOOL		
☐ OTHER		

CURRENT EMPLOYER: (Position) DATES: (From) (To) **PRESENT**

PREVIOUS EMPLOYER: (Position) DATES: (From) (To)

VOLUNTEERING INFORMATION

LIST ALL PREVIOUS VOLUNTEER EXPERIENCE & DESCRIBE DUTIES:

WHAT TYPE OF SERVICE WOULD YOU LIKE TO VOLUNTEER FOR AT **THIS HOSPITAL**? (check all that apply) :

☐ PATIENT ☐ MAIL ROOM ☐ FILING ONLY ☐ FLOATER (Special Projects)
☐ BUSINESS OFFICE ☐ PRINT SHOP ☐ TYPING ONLY ☐ OTHER (Describe Below)
☐ MEDICAL SUPPLY ☐ INFORMATION DESK ☐ SECRETARIAL ______

WHAT TYPE OF SERVICE WOULD YOU LIKE TO VOLUNTEER FOR AT **ASSISTED LIVING**? (check all that apply) :

☐ ACTIVITY THERAPY ☐ EDUCATION ☐ MAINTENANCE ☐ UNIT CLERK
☐ ADMISSION ☐ FOOD SERVICE ☐ REHABILITATION ☐ OTHER (Describe Below)

WHAT DAYS & HOURS ARE YOU AVAILABLE TO VOLUNTEER?

WHAT DATE & TIME ARE YOU AVAILABLE TO START?

VOLUNTEERING INFORMATION (Continued)

ARE YOU WILLING TO ASSIST STAFF IN THE EVENT OF AN EMERGENCY? ☐ NO ☐ YES

IF "YES", HOW LONG WOULD IT TAKE YOU TO GET TO THE HOSPITAL FROM HOME?
☐ 5 Minutes ☐ 15 Minutes ☐ 30 Minutes ☐ 45 Minutes ☐ ≥ 1 Hour

PLEASE LIST ANY SPECIAL SKILLS / INTERESTS:

REFERENCES / EMERGENCY CONTACTS / HEALTH STATUS

LIST 2 ADULTS, WHO ARE NOT FAMILY MEMBERS, THAT CAN BE CONTACTED AS REFERENCES:

NAME	RELATIONSHIP	PHONE NUMBER

IN CASE OF EMERGENCY NOTIFY:

NAME	RELATIONSHIP	PHONE NUMBER

ARE THERE ANY HEALTH REASONS THAT MIGHT LIMIT YOUR ABILITY TO VOLUNTEER? ☐ NO ☐ YES (Describe) > > ____________________

A Physical Status Verification Form (provided by the VOLUNTEER SERVICES OFFICE) from your Doctor is required.

CONSENT

As a volunteer at THIS HOSPITAL, I agree to:

1. Commit to at least a 3 month term of volunteer service;
2. Be interviewed, photographed, videotaped and/or paraphrased for hospital Public Relations & promptional purposes;
3. Conduct myself with dignity, courtesy and respect towards others;
4. Produce the best quality of work possible;
5. Maintain confidentiality concerning all patients and healthcare business;
6. Be punctual and conscientious in the fulfillment of my duties. If I am late or absent for my assignment, I will notify my assignment supervisor and
7. Attend in-service meetings as scheduled when requested;
8. Refer assignment related questions, concerns and/or suggestions to my assigned supervisor first, and then to the Director of Volunteer Services;
9. Adhere to Hospital's volunteer dress code;
10. Comply with all standards, policies, procedures and values of this Hospital, the Department(s) that I am performing volunteer work for, and Volunteer Services Department; and
11. Obey all applicable District of Columbia & Federal laws.

I understand that documentation of my service will be released upon request only after the minimum 3 month term of service has been completed. I certify that the information contained in this volunteer application is true, correct and complete to the best of my knowledge. I authorize the Volunteer Services Department to make relevant inquiries pertaining to all statements made in this volunteer application. I understand that this information shall remain confidential.

SIGNATURE OF APPLICANT ____________________ DATE ____________________

(If Applicant <18 Years Old) SIGNATURE OF PARENT / GUARDIAN ____________________ DATE ____________________

Thank You for Volunteering at YOUR HOSPITAL !