

Volunteer Application

This application is for anyone 15 years of age and older. Please provide as much information as possible. We will place you in the volunteer opportunity that best suits your interest.

REFERRED BY: _____

Please Print:

Date _____

First Name _____

Last Name _____

Nickname (if applicable): _____

Date of Birth _____

Address _____

City _____ State _____ Zip _____

Home Phone _____

Cell Phone _____

E-Mail _____

Spouse's or Parent's Name _____

Do you work Full-time Part-time Retired Student GPA _____

Occupation & Title _____

Employer or School _____

Education _____

Community Affiliations _____

Foreign Language(s) _____

Interests and Hobbies _____

Volunteer Experience _____

Physical Limitations/Medications _____

Have you ever been convicted of a felony? Yes No

Preferred Method of Communication:

Do you have reliable transportation to/from the hospital? Yes No Home Phone Cell Phone Text Email

For Adult Volunteers: Are you able to commit to a minimum of one, four-hour shift per week for at least six months? Yes No

For Teen Volunteers (Age 15-17): Are you able to commit to a minimum of one, four-hour shift per week for at least three months?

Yes No

Where did you learn about Palm of Pasadena's volunteer opportunities? _____

Check the times you are most available to serve:

Weekdays Weekends Mornings Afternoons Evenings Preferred Day _____

Check the volunteer opportunities you are interested in. This will help us know where to place you:

- | | | |
|--|---|--|
| <input type="checkbox"/> Newspapers | <input type="checkbox"/> Education | <input type="checkbox"/> Volunteer Office |
| <input type="checkbox"/> Bariatrics | <input type="checkbox"/> Nursing Services | <input type="checkbox"/> HIM/Medical Records |
| <input type="checkbox"/> One Day Surgery | <input type="checkbox"/> Surgery Waiting Room | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Information Desk/Front Desk | <input type="checkbox"/> Radiology | |
| <input type="checkbox"/> Pharmacy | <input type="checkbox"/> Transport | |
| <input type="checkbox"/> Lab | <input type="checkbox"/> Emergency Room | |

I want to become a Palms of Pasadena Hospital Volunteer because: _____

In case of an emergency, please notify:

Name _____ Relationship _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____
Physician _____ Office Number _____

Please list two people other than relatives who would be willing to serve as personal references:

Name _____ Relationship _____
Phone _____ Email _____
Name _____ Relationship _____
Phone _____ Email _____

Please sign:

I certify that the statements made in this volunteer application are true and correct, and have been given voluntarily. I understand that this information may be disclosed to any party with legal and proper interest, and I release Palms of Pasadena Hospital from any liability whatsoever for supplying such information.

After your application has been reviewed, your placement for volunteer service will be determined and an orientation will be scheduled followed by a free TB test.

Applicant's Signature _____ **Date** _____

For Office Use Only:	<input type="checkbox"/> Interview _____	<input type="checkbox"/> Bgrd Chk _____	<input type="checkbox"/> TB Test _____
<input type="checkbox"/> Entered _____	<input type="checkbox"/> Orient _____	<input type="checkbox"/> TB Test _____	<input type="checkbox"/> TB X-Ray _____
<input type="checkbox"/> Badge _____	<input type="checkbox"/> Uniform _____	<input type="checkbox"/> Start Date _____	
<input type="checkbox"/> Area of Service _____	<input type="checkbox"/> Other _____		