

# Hollywood Presbyterian Medical Center

## APPLICATION FOR VOLUNTEER SERVICE

Vol. No. \_\_\_\_\_

Mr/Mrs		
Miss/Ms		
	Last Name	First Name
Address	Telephone	
City	State	Zip Code
E-Mail Address		
Social Security Number		Date of Birth

**EXPERIENCE: Please include hospital, medical or related experience if applicable.**

Volunteer: \_\_\_\_\_

Paid: \_\_\_\_\_

Education / Special Training / Languages: \_\_\_\_\_

\_\_\_\_\_

**TIME AVAILABLE:**

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Morning							
Afternoon							
Evening							

Why did you decide to volunteer at Hollywood Presbyterian Medical Center?

\_\_\_\_\_

\_\_\_\_\_

**Over** ⇒

**LIMITATIONS RELATED TO HEALTH:**

Do you have any physical condition or medical problem in which it may limit your ability to perform the work of a volunteer?

Yes                      No

If "YES," please explain: \_\_\_\_\_

Volunteers under care of a doctor will be required to submit a written permission to volunteer.

In case of emergency, please notify: \_\_\_\_\_

Have you ever been convicted of a crime? \_\_\_\_\_ If yes, explain when, where, and disposition of case \_\_\_\_\_

I agree that the above information is correct as of the date it has been filed.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

OPPORTUNITIES FOR VOLUNTEERS ARE PROVIDED WITHOUT REGARD TO RELIGION, CREED, RACE, NATIONAL ORIGIN, AGE OR SEX

**FOR OFFICE USE ONLY: Volunteer Type (circle) Jr.   Adult   Arch.   RX Intern   ROP**

Volunteer Number	Orientation _____		
Assignment	Code Number _____		
Schedule	Service Description _____		
Starting Date	Badge	given	returned
Uniform	Orientation Checklist	given	returned
PPD/X-Ray	Re-Orientation _____		

Comments \_\_\_\_\_

Counseling Date: \_\_\_\_\_

Termination Date \_\_\_\_\_ Reason \_\_\_\_\_

Rev. 9/97

Reviewed 3/01, 6/02

Revised 01/04,8/04