

# Volunteer Application

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Street Address \_\_\_\_\_

City, State and Zip Code \_\_\_\_\_

Telephone Number \_\_\_\_\_ Social Security Number \_\_\_\_\_  
(used for background screening)

Email address \_\_\_\_\_ Date of Birth \_\_\_\_\_

Male  Female  City and State of your birth \_\_\_\_\_

**Emergency information** (In case of emergency, notify the following)

Name \_\_\_\_\_ Telephone Number \_\_\_\_\_

Address \_\_\_\_\_ Relationship to you \_\_\_\_\_

**Education and employment history**

Current Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Current grade: High School  8  9  10  11  12 College:  1  2  3  4  5

Name of high school or college attending  
 \_\_\_\_\_

**Skills/preferences** (check all that apply)

- Helping Visitors     
  Clerical/Office Work     
  Computer Skills  
 Helping Patients     
  Mailings/Special Projects     
  Other \_\_\_\_\_

**Availability** (please check the days and times you are most available to volunteer)

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning							
Afternoon							
Evening							

**General information:**

Are you required to volunteer or perform community service?  Yes  No

If yes, by whom? \_\_\_\_\_ How many hours? \_\_\_\_\_

When do the hours have to be completed? \_\_\_\_\_

How did you hear about our volunteer program? \_\_\_\_\_

State briefly why you wish to volunteer at University Medical Center? \_\_\_\_\_

List any previous volunteer experience \_\_\_\_\_

I certify that the facts set forth on this application are true and complete to the best of my knowledge. I authorize University Medical Center to make any investigation of my personal history, financial and credit record through any investigative or credit agencies or bureaus of your choice. I have read, understand and, by my signature, consent to these statements.

<b>Volunteer Signature</b> X	<b>Date</b>
<b>Parent/Guardian Signature (if under 18 years of age)</b> X	<b>Date</b>

**For office use only:**

- Completed application
- Background screening completed
- TB screening and immunization verification completed
- Orientation completed
- ID acquired
- Meals loaded
- Uniform received
- Touch Points completed

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Questions/concerns/issues, contact Laurie Smith  
Office: 504.702.4160  
Fax: 504.702.3275  
Email: laurie.smith@lcmchealth.org