Email: _____

VOLUNTEER SERVICE APPLICATION

Date: _____

Mr./Miss/Mrs.: _____
Last Name First Spouse's Name

Address: _____
Street City Zip Code

Phone: _____ **Birth date: _____**

If employed, name of business: _____

Occupation: _____ **If retired, previous occupation: _____**

Education: _____

Special skills & abilities: _____

Availability: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

Hours: _____

Reason for selecting Gottlieb Memorial Hospital: _____

_____

EMERGENCY CONTACT:

Name: _____ **Relationship: _____**

Address: _____ **Phone: _____**

Family Physician: _____ **Phone: _____**

PERSONAL REFERENCES:

Name: _____ **Phone: _____**

Address: _____

Name: _____ **Phone: _____**

Address: _____

As a Volunteer at Gottlieb Memorial Hospital, I will endeavor to be regular in my attendance and service, to perform the duties assigned to me, and observe all hospital regulations to the best of my ability.

_____
Signature

Date: _____

I, _____ give my consent to have all laboratory tests to determine proof of immunity to Measles, German Measles, Mumps and Chicken Pox, a TB skin test and/or chest X-ray, if the TB skin test is positive.

_____ _____

(Signature) (Print)

_____ _____

(Relationship) (Date)

_____ _____

(Witness) (Date)

EMERGENCY TELEPHONE NUMBERS:

NAME	RELATIONSHIP	HOME	WORK

DATE: _____

I give my consent for my son/daughter _____ to have all laboratory tests, if unable to provide proof of immunity to measles, German measles, and chicken pox, a TB skin test and/or chest X-ray if the TB skin test is positive, and a modified physical examination as required for volunteer work at Gottlieb Memorial Hospital.

I also give my consent for the Employee Health Service Department or the Emergency Department at Gottlieb Memorial Hospital to give emergency care for illness and/or for injury sustained by _____ while he/she is at work.

_____ _____

(Print) Parent/Legal Guardian (Signature) Parent/Legal Guardian

_____ _____

Relationship Date

_____ _____

Witness Date

EMERGENCY TELEPHONE NUMBERS:

NAME	RELATIONSHIP	HOME	WORK

GOTTLIEB MEMORIAL HOSPITAL

STUDENT VOLUNTEER APPLICATION FORM

DATE: _____ BIRTHDATE: _____

NAME: _____

ADDRESS: _____

PHONE: _____

Person to contact in case of illness on duty:

Name: _____Phone #: _____

Relationship: _____ Family Physician: _____

School: _____ Year: _____

Degree Pursuit, Hobbies, Skills, Special Interests: _____

_____

Previous Volunteer Experience: _____

_____

Signature of Student

(If younger than 18, parent please complete below)

_____ has my/our consent to serve as a
Name

Student Volunteer at Gottlieb Memorial Hospital.

_____

Parent or Guardian Signature

_____

Phone Number Date

VOLUNTEER INFORMATION FORM
GOTTLIEB MEMORIAL HOSPITAL

_____ _____
Social Security # Date of Physical

_____
Volunteer Start Date

Name:_____
First Middle Last

Address: _____
Number Street Unit #

_____
City State Zip Code

Telephone #:_____Cell Phone #:_____

Date of Birth: _____

RACE

(01) ☐ White

(02) ☐ Black or African American

(03) ☐ Hispanic or Latino

(04) ☐ Native Hawaiian or other Pacific Islander

(05) ☐ Asian

(06) ☐ American Indian or Alaskan Native

(07) ☐ Two or More Races

(08) ☐ Preference not indicated

SEX

☐ Male

☐ Female

EMERGENCY CONTACT INFORMATION