

VOLUNTEER APPLICATION

NAME: _____

HOME ADDRESS: _____
Street City/State Zip Code

TELEPHONE NUMBER: _____ (H) _____ (C)

BIRTHDATE: _____

AREA OF INTEREST:

Is there a specific area in which you would like to volunteer? _____

Date you would be available to start? _____

Days and hours you are available to volunteer? _____

Please check two (2) areas you are interested in volunteering from the choices listed below:

WEEKDAY OPPORTUNITIES:

(Must be able to volunteer between 9:00 am –4:00 pm)

- Gift shop (hours are 9am-7pm)
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Recreation Therapy
- Clerical/Office Work
- Storeroom
- Dietary
- Pharmacy
- Patient Care Assistant

EVENING & WEEKEND OPPORTUNITIES:

- Gift Shop (4-7pm eves & 12-5pm wkends)
- Patient Care Assistant
- Clerical/Office work
- Greenhouse/healing garden
- Physical Therapy
- Occupational Therapy
- Recreation Therapy
- Dietary

Are you employed? Yes ___ No ___ If so, may we inquire of your present employer? Yes ___ No ___

Have you ever volunteered before? Yes ___ No ___

Where and when (give dates):

Volunteer position(s) held:

Have you ever worked for Kernan Hospital or University of Maryland Medical System? Yes ___ No ___

Where and when (give dates):

Position held:

Comments:

EDUCATION:

<u>Name & Location of School</u>	<u>Years Attended</u>	<u>Highest Level Completed</u>	<u>Major/GPA</u>
High School			

College _____

Trade Business or Correspondence School _____

MOST RECENT EMPLOYERS:

Date:	Name & Address of Employer	Position
From: _____	_____	_____
To: _____	_____	
From: _____	_____	_____
To: _____	_____	

OTHER SPECIAL SKILLS: (fluency in language, computer skills, arts & crafts etc.) _____

IN CASE OF EMERGENCY, CONTACT:

_____	_____	_____
Name	Relationship	Phone

REFERENCES: Give the 2 enclosed reference forms to two individuals who are not related and have known you for at least one year. (For minors, one of the references must be from a teacher.) **The references and application must be returned to this office before an interview will be scheduled. (The references may be returned with the application or separately.)**

Your signature below indicates that the facts contained in this application are true and complete to the best of your knowledge. If selected as a volunteer, falsified statements on this application shall be grounds for dismissal. As a safeguard to health, I understand I will be required to pass a physical assessment. I also understand I will be required to complete forms for a criminal background check. The organization is not obligated to provide placement, nor are you obligated to accept the service position offered.

Applicant's Signature: _____ Date: _____

PARENTAL/GUARDIAN PERMISSION:

My son or daughter is in good health and has my permission to volunteer at Kernan Hospital and may be provided Emergency medical care if necessary when on duty at the hospital. I realize the responsibility of the organization and will cooperate with my child to comply with its regulations, which includes providing transportation and seeing that my child faithfully maintains his/her schedule.

Parent/Guardian Signature: _____ Date: _____

Relationship to Minor: _____

EOE, M/F/D/V

RETURN TO:

KERNAN ORTHOPAEDICS & REHABILITATION
VOLUNTEER SERVICES
2200 KERNAN DRIVE
BALTIMORE, MD 21207

FOR OFFICIAL USE ONLY:

Starting Date: _____
Assignment: Area - _____
Days - _____
Hours - _____
Est. Length of Service: _____
Comments: _____