THE WASHINGTON HOSPITAL

DEPARTMENT OF VOLUNTEER SERVICES

COLLEGE VOLUNTEER APPLICATION

Name:____ Date of Application:____________________

Home Address:____

Street City State Zip

Local Address: ____

Telephone:_________________________E-mail:______________________________Birthdate:_____________

College or Technical School:_________________________Year:_________Graduation Date:_______________

Major: ____ SS#: _______________________________

Emergency Contact:____

(Name) (Relationship) (Phone)

Parent/Guardian: ____

(Name) (Relationship) (Phone)

Current Employer:____

(Phone)

Duties/Responsibilities:____

Can you be contacted at work? Yes____ No____

How did you hear of this volunteer program?____

Volunteer Experience (if any):____

Skills, Hobbies, Interests:____

Physical Limitations:____

References:____

(Name) (Address) (Phone)

____

(Name) (Address) (Phone)

Is volunteering required for your major? Yes____ No____ If yes, how many hours are required:_____________

Why are you interested in volunteering?____

What days and hours are you available? (Minimum commitment is 3 hours once a week for 3 consecutive months) ____

Have you ever been convicted of a felony? Yes ____ No ____ describe in full below. (A past conviction does not necessarily prevent you from being considered for volunteer work.)

____

Are you available in the evening? ___yes ___no On the Weekends? ___yes ___no

VOLUNTEER CONTRACT

1. I shall abide by all hospital rules and regulations and will follow guidelines outlined in the position description.

2. I understand that all patients have a right to be treated in a respectful manner and to have their privacy protected. I agree not to discuss the facts of a patient's case with anyone, and shall maintain the confidential nature of all information I may obtain during the course of my volunteer assignment.

3. I understand that in addition to a general orientation, I may receive specific training for various assignments, throughout the hospital in cooperation with requesting departments.

4. I will notify the Volunteer Department and/or my assigned supervisor when I am unable to report to duty.

5. I will not accept money or "tips" for my services and I will be responsible for all my own personal expenses.

6. I understand the hospital, at it's own discretion, may terminate or suspend me from the program if it believes such action is warranted; in particular, violation of hospital policies or breaching confidentiality.

________________________________ ____

(Date) (Signature)

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FOR OFFICE USE ONLY

Interviewed:____________ Oriented:_____________ TB Test: _____________ Uniform:______________________

Comments:____

____

Confid. Signed: ____________ Photo ID: __________ Immuniz. To EH: _____________ Dues paid:____________

Assigned To: _____________________________ Training Form(s) Sent: _____________________________

Computer Date Entered: ______________ Volunteer ID # _________ Created Volunteer File: _______________

Form 017 Revised: 1/01, 3/04, 4/07, 6/08, 9/10