VOLUNTEER APPLICATION

Date Received______________________________

Application ___Complete _______Incomplete

Date Interviewed____________________________

Volunteer Type_____________________________

PERSONAL INFORMATION:

____

Last Name First Name MI

____

Address (Apt. #) City Zip Code

Phone_______________Cell Phone____________________Email____________________________

Date of Birth: _____/_____/_____ Social Security # (last 4 digits only)_________________

EDUCATION: ______High School ______College ______Post Graduate

Degree(s)____

Are you a current student? ____Yes ____No Expected graduation date________________

Are you a year-round resident? ____Yes ____No

If not, what months are you available? ____

WORK STATUS: ______Employed ______Retired ______Unemployed

Current or last place of employment____

IN AN EMERGENCY PLEASE NOTIFY:

Name____Relationship______________________

Address____Home Phone_____________________

____Work Phone______________________

Physician____Phone___________________________

Have you ever applied to be an Enloe Volunteer before? _____Yes ______No

How did you hear about Enloe Volunteers? ____

____

Volunteer Services
249 W. Sixth Ave., Chico, CA 95926 ● (530) 332-4575 ● www.enloe.org/volunteers

Are there any work activities or conditions that you must avoid? ______Yes ______No
If Yes, please describe____

Have you ever committed, been convicted of, pled guilty to, or pled no contest to a felony or a misdemeanor? NOTE: Conviction of a crime is not necessarily grounds for disqualification.
______Yes ______No If Yes, please explain____

What do you hope to gain from your volunteer experience? ______________________________

____

____

____

Have you volunteered in a healthcare setting before? ______Yes ______No

If Yes, describe the experience____

____

What about the healthcare setting is appealing to you?_____________________________

____

____

PERSONAL REFERENCES:

Please provide complete names and addresses of references. References should not be related to you or live at the same address. To process your application, ***reference information must be complete.***

1. Name_______________________________________Telephone____________________

Address____

City________________________State_____________Zip Code___________________________

Relationship______________________________How long have you known?__________________

2. Name_______________________________________Telephone____________________

Address____

City________________________State_____________Zip Code___________________________

Relationship______________________________How long have you known?__________________

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By signing below I certify that the information provided in this application is true in all respects, without any willful omissions. I understand that if this application is false in any way, I will be dismissed without notice regardless of when the false information is discovered.

By signing below I hereby authorize Enloe Medical Center to use photographs taken for marketing, public relations, recruitment, and educational purposes and waive any right to compensation for these uses. The term photograph shall mean motion picture or still photography in any format, as well as videotape, video disc, digital, electronic or other mechanical means of recording and reproducing images.

Signature____Date________________

Volunteer Health Questionnaire

Physician Name ____

Medical History

Have you every suffered an injury or illness that temporarily limited your physical activities? If so please list:

Date (month/year) Type of illness/injury Treatment Limitation

____

____

____

Immunity Status

Have you had the following diseases or immunizations?

Measles/Mumps/Rubella (MMR): ____Disease ____Immunization ____Unknown
Tetanus/Diptheria/Pertussis ____Disease ____Immunization ____Unknown
Chickenpox (Varicella): ____Disease ____Immunization ____Unknown

Influenza (flu) Immunization: Have you been immunized this year? Yes No
If yes, date and location: _______________________

Have you completed the three-part Hepatitis B vaccination series? Yes No
Year Completed ___________________ Where _________________________________

I herby certify, to the best of my knowledge, the foregoing answers are complete and correct. I authorize the release of the results of this questionnaire to Enloe Medical Center Volunteer Services and the Employee Health Department. Any further release will be guided by the provisions of the Confidentiality of Medical Information Act.

Signature ____ Date ___________________