VOLUNTEER APPLICATION

Last Name: First Name: MI:

Address:

City: State: ZIP:

Cell: Home: Email:

Birth date: Age: ☐ 14-17 ☐ 18-25 ☐ 26-35 ☐ 36-50 ☐ 51-59 ☐ 60+

Preferred Type(s) of work: ☐ Patient Contact ☐ Public ☐ Office ☐ Undecided

Specific Area (if known): Date you can begin:

Number of days per week you are available to volunteer: Hours per day: ☐ 4 ☐ 6 ☐ 8

How long do you plan to volunteer? ☐ 100 hours ☐ 1 year ☐ more than 1 year ☐ summer only

Days/Hours of availability (specify the earliest you can begin and latest you would stop): Sunday:

Monday: Tuesday: Wednesday:

Thursday: Friday: Saturday:

Paid/Volunteer Experience: Current Status: ☐ Retired ☐ Unemployed ☐ Employed ☐ Student

Days/Hours of Employment:

Please list current or most recent position first:

1. Job Title: Dates: From to

Company Name: Supervisor:

City: State: ZIP: Phone:

Duties:

Reason for leaving:

2. Job Title: Dates: From to

Company Name: Supervisor:

City: State: ZIP: Phone:

Duties:

Reason for leaving:

Skills/Hobbies:

Why do you want to volunteer? (check all that apply) ☐ Retired (something to do) ☐ Experience ☐ School Requirement

☐ Mental Health referral ☐ To become employed ☐ Give back to community ☐ Other (specify)

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Languages Spoken: (check all that apply) ☐ English ☐ Spanish ☐ French ☐ Other

Career:	School Name	Attended		Graduated	Major
High School:		From:	To:	☐ Y ☐ N	
College:				☐ ☐	
Other Training:				☐ ☐	

Have you volunteered at HCH before? ☐ Y ☐ N If so, when?

Name (if different than above): Area(s):

How did you become interested in volunteering? ☐ Church bulletin ☐ Employee ☐ Volunteer ☐ Newspaper ☐ Radio ☐ Holy Cross Health ☐ Radio ☐ Montgomery Co. Volunteer Center ☐ School ☐ Other (specify)

Organizations (Clubs, churches, etc.) in which you are a member:

In case of emergency, contact: Name: Relation:

Address:

Cell: Work: Home:

Health Survey: Date of last TB test: Reaction: ☐ Negative (no reaction) ☐ Positive (swollen, reddened)

Check those applicable to you and elaborate if you wish: ☐ Back problems ☐ Blind ☐ Diabetic ☐ Epilepsy ☐ Hard of hearing ☐ Mental Health Problems ☐ Tuberculosis (TB) ☐ Other (specify)

References: List two people in the Washington DC Metro area, preferably a supervisor or co-worker, who have known you longer than one year. Do not include relatives.

Name	Capacity	Known (How long)	Daytime Phone

I verify the information on this application is correct:

Signature of Applicant Date