Beth Israel Deaconess Medical Center

Application for Volunteer Service

330 Brookline Avenue, GZ - 210
Boston, MA 02215 617-667-3026

An Affirmative Action Equal Opportunity Employer

Thank you for applying for a volunteer position with Beth Israel Deaconess Medical Center. We will make every effort to match your skills and interests with current or future openings. We cannot consider incomplete applications. Applications **must include** two letters of reference on letterhead from persons who have known you for several years, (e.g. rabbi, priest, minister, physician, teacher, counselor or employer). Letters from relatives or personal friends are not acceptable. We appreciate your interest in our organization.

Please Print Clearly Date_____

Name_____
(Last) (First) (Middle Initial)
Address_____
(Street) (City) (State) (Zip Code)
Telephone_____(H)_____(W) Email _____

Can you commit to giving BIDMC a 1 day, 4 hour shift per week for a minimum of six months? Yes ❑ No ❑

Check Times Available: Mornings____Afternoons____Evenings____
Mondays_____Tuesdays_____Wednesdays_____Thursdays____Fridays____Weekends____

Why do you want to volunteer at BIDMC?

_____

_____

_____

Education	**Name of School**	**Address**	**Dates Attended? From**	**To**	**Did you Graduate?**	**Major Subject**	**Degree Received or # of years completed**
High School							
College or School of Nursing							
Technical/Business School							
Other							

Employment experiences: List your most recent position first. (Do not leave blank, even if self-employed)

Name and Address	**Dates:** **From:** **To:**	**1. Position held** **2. Supervisor 3. Telephone**	**Reason for Leaving**
		1. 2. 3.	
		1. 2. 3.	

PREVIOUS VOLUNTEER EXPERIENCE:

Where?	Dates: From: To:	What was your assignment?

- Who referred you to Beth Israel Deaconess Medical Center? _____

- Do you have any particular skills that would be helpful in a volunteer assignment?

_____

- What languages do you speak? Please list _____

- In case of an emergency, whom do you wish us to notify?

Name_____Relationship_____Telephone_____

PLEASE READ CAREFULLY AND SIGN THE STATEMENT BELOW

I certify that the information given above is true and complete and I understand that misrepresentation and/or withholding of information will result in the rejection of this application or my discharge if discovered after volunteer service begins. I authorize the Medical Center to make inquiries regarding my history and character of prior employers, schools, etc. and hereby release employers, schools or individuals from all liability in responding to inquiries in connection with my application and release the Medical Center from all liability with respect to such inquiries.

I understand that if I am a volunteer, I will be a volunteer "at will" and may terminate my volunteer assignment at any time with or without cause or notice and that the Medical Center also has that right. I also understand no representative of the Medical Center, other than the President, has any authority to enter into any agreement for volunteer service for any specified period of time or to make any agreement contrary to the foregoing and that such agreement must be in writing. As a volunteer, I agree to abide by the Medical Center's policies, rules and procedures and any changes thereto.

I understand that I must provide the Medical Center with updated immunization records that include verification of a Tuberculosis test within the past year. If under 18 years of age, please use the enclosed parental consent form.

_____ _____

Applicant's Signature Date