UNIVERSITY HEALTH CARE SYSTEM

VOLUNTEER APPLICATION

1350 Walton Way • Augusta, Georgia 30901 • 706-774-2208

www.universityhealth.org

(Please Print)

Name _____
Last First Middle

Home Address _____
Number Street City State Zip Code

Home Telephone (_____)_____ E-mail Address _____
Area Code

Business Address _____
Number Street City State Zip Code

Business Telephone (_____)_____ Cellular Phone (_____)_____
Area Code Area Code

When are you able to volunteer? ❑Morning ❑Afternoon ❑Evening ❑Weekends

Best day of the week to volunteer _____

What area(s) are you interested in? _____

PERSONAL RECORD

Emergency Contact_____ Telephone_____

Date of Birth (Month and Date Only) _____ /_____

Are you under 18 years of age? If yes, what is your date of birth? _____/_____/_____
month date year

Have you ever been convicted of a crime? (Other than minor traffic violations) ❑Yes ❑No

If Yes, explain _____
(Criminal background checks are done on all applicants)

EDUCATION RECORD

School/City	Years Attended From	Years Attended To	Degrees Received

List any occupational skills, special talents or hobbies _____
_____
_____

WORK/VOLUNTEER HISTORY (List Present or Most Recent Experience First):

1. Employer/Volunteer Station_____

Address _____ Phone_____

Description of your work_____

Reason for leaving _____

May we contact this employer/volunteer station? ❑Yes ❑No

2. Employer/Volunteer Station_____

Address _____ Phone_____

Description of your work_____

Reason for leaving _____

May we contact this employer/volunteer station? ❑Yes ❑No

PERSONAL REFERENCES (Not Relatives)

1._____

Name Address Phone No. Relationship

2._____

Name Address Phone No. Relationship

I hereby declare that all the above statements are true and correct to the best of my knowledge, and I hereby authorize University Hospital to make any inquiries to determine my ability for volunteer service, with the understanding that any misrepresentation I make will be just and due cause for non-acceptance or dismissal as a volunteer. If qualified for volunteer service, I agree to abide by the rules and regulations of University Hospital, the policies and procedures of the volunteer program and the department to which I am assigned, and I will respect the confidentiality of patient information at all times. I understand and agree that I will not be compensated for any volunteer service I perform for University Hospital.

_____

Signature Date

INTERVIEWED BY:

_____ _____

Name Title Date Director of Volunteer Services Date

FOR OFFICE USE: