

VOLUNTEER APPLICATION

PERSONAL INFORMATION (Please type or print) SOCIAL SECURITY #- _____ - _____ - _____

NAME (LAST NAME FIRST) _____ DATE OF BIRTH _____

PRESENT ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE # _____ WORK PHONE# _____

Email Address: _____ Nationality: _____ Gender: _____

AREA OF INTEREST _____

DATE YOU CAN START _____

ARE YOU EMPLOYED? _____ YES _____ NO Name of Employer _____

POSITION: _____ MAY WE INQUIRE WITH YOUR EMPLOYER? _____ YES _____ NO

HAVE YOU EVER VOLUNTEERED BEFORE? _____ YES _____ NO

WHERE? _____ WHEN? (GIVE DATES) _____ POSITION(S) _____

PERSON TO CONTACT IN CASE OF EMERGENCY

NAME _____ RELATIONSHIP _____

DAY PHONE AND CELL NUMBERS: _____

EDUCATION

<u>NAME AND LOCATION OF SCHOOL</u>	<u>YEARS ATTENDED</u>	<u>HIGHEST LEVEL COMPLETED</u>	<u>SUBJECT STUDIED</u>
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HIGH SCHOOL

_____	_____	_____	_____
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COLLEGE

_____	_____	_____	_____
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TRADE, BUSINESS OR CORRESPONDENCE SCHOOL

_____	_____	_____	_____
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OTHER SKILLS OR TRAINING: (FLUENCY IN LANGUAGE, WORD PROCESSING SKILLS ETC.)

WOULD YOU ACT IN THE CAPACITY OF AN INTERPRETER? YES ___ NO ___

REFERENCES:

Give below the names of two references not related to you, whom you have known at least one year.

NAME	ADDRESS	PHONE NUMBER
1. _____	_____	_____
2. _____	_____	_____

HAVE YOU EVER BEEN CONVICTED OR PLEAD GUILTY IN COURT (EVEN IF YOU DID NOT HAVE A TRIAL) FOR ANYTHING OTHER THAN A MISDEMEANOR OR MINOR TRAFFIC VIOLATION?" YES OR NO. IF YES, PLEASE EXPLAIN: _____

AUTHORIZATION

TO THE APPLICANT: IF YOU ARE NOT A MINOR YOUR SIGNATURE AUTHORIZES US TO PERFORM NECESSARY TESTS WHICH MAY INCLUDE THE DRAWING OF BLOOD, IF YOU ARE UNABLE TO PROVIDE DOCUMENTATION OF INFORMATION REQUIRED ON THE HEALTH FORM ATTACHED WITH THIS APPLICATION.

YOUR SIGNATURE ALSO, INDICATES THAT THE FACTS CONTAINED IN THIS APPLICATION ARE TRUE AND COMPLETE TO THE BEST OF YOUR KNOWLEDGE. IF EMPLOYED AS A VOLUNTEER, FALSIFIED STATEMENTS ON THIS APPLICATION SHALL BE GROUNDS FOR DISMISSAL. YOU AUTHORIZE APPROVAL TO CHECK REFERENCES AND TO CONTACT YOUR PHYSICIAN REGARDING YOUR PHYSICAL AND EMOTIONAL HEALTH. THE ORGANIZATION IS NOT OBLIGATED TO PROVIDE A PLACEMENT, NOR ARE YOU OBLIGATED TO ACCEPT THE POSITION OFFERED. PLEASE ALSO BE ADVISED THAT BY SIGNING, YOU AUTHORIZE UNIVERISTY OF MARYLAND MEDICAL CENTER TO CONDUCT A BACKGROUND INVESTIGATION.

SIGNING UP AS A VOLUNTEER IN NO WAY GUARANTEES A PAID POSITION HERE AT UNIVERITY OF MARYLAND MEDICAL CENTER OR SYSTEM. PLEASE SIGN HERE: _____

APPLICANTS SIGNATURE _____ DATE _____

PARENTAL CONSENT: IF YOU ARE A MINOR UNDER THE AGE OF 18 PLEASE HAVE A PARENT OR LEGAL GUARDIAN SIGN.

NOTE TO PARENT/LEGAL GUARDIAN (S): YOUR SIGNATURE INDICATES THAT YOUR SON/DAUGHTER IS IN GOOD HEALTH AND HAS YOUR PERMISSION TO VOLUNTEER AT UMMS. IT ALSO AUTHORIZES US TO PERFORM THE NECESSARY TESTS TO OBTAIN MEDICAL INFORMATION REQUIRED WITH THIS APPLICATION. THIS PROCEDURE MAY INCLUDE THE DRAWING OF BLOOD. YOUR SIGNATURE ALSO AUTHORIZES EMERGENCY MEDICAL CARE WHILE YOUR SON/DAUGHTER IS ON DUTY AT THE HOSPITAL.

PARENT OR GUARDIAN'S NAME _____

SIGNATURE _____