

Volunteer Application Form

Date: _____

PERSONAL INFORMATION:

LAST NAME: _____ FIRST NAME: _____ MI: _____

EMAIL: _____ PHONE: _____

AGE GROUP: SENIOR (55+) ADULT (18+) TEEN (16-17) TEEN (15-)

HIGH SCHOOL GRADUATE? YES NO EXPECTED GRADUATION YEAR: _____

LANGUAGES: ENGLISH SPANISH FRENCH OTHER: _____

CURRENT OCCUPATION: _____

EMERGENCY CONTACT:

NAME: _____

PHONE: _____ RELATIONSHIP: _____

KNOWN ALLERGIES: _____

PREFERENCES:

TYPE OF WORK: _____

AVAILABILITY: WEEKDAYS WEEKENDS HOLIDAYS

HOURS: MORNINGS AFTERNOONS EVENINGS

PREVIOUS EXPERIENCE:

VOLUNTEER: _____

EDUCATION / PROFESSIONAL LICENSE: _____

SPECIAL SKILLS:

Please indicate any special skills or training you may have:

TELL US WHY YOU WANT TO VOLUNTEER AT **LVMC** **CCC** (circle location)

BACKGROUND:

Have you ever volunteered for LVMC before? NO YES. If yes, when? _____

Have you ever worked for LVMC before? NO YES. If yes, when & where? _____

Do you have any limitations that would affect your ability to perform as a volunteer with or without reasonable accommodations? YES NO. EXPLAIN: _____

Are you legally authorized to volunteer for LVMC? YES NO. EXPLAIN: _____

REFERENCES:

NAME: _____

PHONE: _____ RELATIONSHIP: _____

NAME: _____

PHONE: _____ RELATIONSHIP: _____

DISCLAIMER AND SIGNATURE:

ADULT APPLICANT

I hereby affirm that the provided information on this application is true and complete to the best of my knowledge and agree to have any on the statements checked by LVMC or its representatives. I understand that providing any false or misleading information or any omissions may disqualify me from further consideration as a volunteer and may result in my position being rescinded, even if discovered at a later date.

ADULT SIGNATURE: _____ DATE: _____

TEEN APPLICANT

I hereby give my consent for my son/daughter to participate in the LVMC Volunteer Program. I understand that my child must regularly attend scheduled shifts to remain in the program. I will assume full responsibility for the required transportation to and from the hospital, and I agree to support the requirements.

TEEN SIGNATURE: _____ DATE: _____

PARENT OR GUARDIAN: _____ DATE: _____

Return the completed and signed form to:

LVMC: Nora Wallace
(805) 737-5749 wallacen@lompocvmc.com

CCC: Michele Hunt
(805) 736-3466 huntm@lompocvmc.com