



VOLUNTEER APPLICATION

TODAY'S DATE: _____ A _____ J/HS _____ COL _____ SY _____

PERSONAL DATA	NAME <small>Last</small> _____ <small>First</small> _____ <small>Middle</small> _____			SPOUSE'S NAME: _____		
	MAILING ADDRESS <small>Street & No.</small> _____ <small>City/Town</small> _____ <small>State</small> _____ <small>Zip</small> _____					TELEPHONE NO. _____
	PRESENT ADDRESS <small>Street & No.</small> _____ <small>City/Town</small> _____ <small>State</small> _____ <small>Zip</small> _____ <small>(if different)</small>					CELL PHONE NO. _____
	HAVE YOU EVER VOLUNTEERED AT NYU LUTHERAN MEDICAL CENTER? <input type="checkbox"/> YES <input type="checkbox"/> NO			HOW DID YOU HEAR ABOUT VOLUNTEER WORK AT NYU LUTHERAN MEDICAL CENTER? <input type="checkbox"/> Newspaper <input type="checkbox"/> Friend <input type="checkbox"/> Relative <input type="checkbox"/> internet <input type="checkbox"/> Other _____		
	HAVE YOU EVER BEEN EMPLOYED BY NYU LUTHERAN MEDICAL CENTER <input type="checkbox"/> , NYU LUTHERAN FAMILY HEALTH CENTERS <input type="checkbox"/> , AUGUSTANA NURSING HOME <input type="checkbox"/> , HEALTH PLUS <input type="checkbox"/> OR PC <input type="checkbox"/> WHEN? _____ WHAT DEPARTMENT _____			E-MAIL ADDRESS: _____		
HAVE YOU EVER APPLIED FOR EMPLOYMENT AT NYU LUTHERAN MEDICAL CENTER? <input type="checkbox"/> YES <input type="checkbox"/> NO IF SO, WHEN? MONTH _____ YEAR _____						

INTERESTS/AVAILABILITY	VOLUNTEER ASSIGNMENT PREFERENCE					
	DEPARTMENT: _____			HOBBIES: _____		
				DO YOU DRIVE? <input type="checkbox"/> YES <input type="checkbox"/> NO		CAR AVAILABLE? <input type="checkbox"/> YES <input type="checkbox"/> NO
	I AM WILLING TO VOLUNTEER			FOREIGN LANGUAGE PROFICIENCY <input type="checkbox"/> YES <input type="checkbox"/> NO		
	DAYS AVAILABLE (CIRCLE ALL): M TU W TH F SA SU			SPEAK: _____ READ: _____ WRITE: _____		
Hours: _____			SPEAK: _____ READ: _____ WRITE: _____			
DATE AVAILABLE TO START _____						
DO YOU KNOW ANYONE (INCLUDING RELATIVES) WORKING AT NYU LUTHERAN MEDICAL CENTER OR AFFILIATES? WHO? WHAT DEPARTMENT DOES HE/SHE/THEY WORK IN? <input type="checkbox"/> YES <input type="checkbox"/> NO DETAILS: _____						

EDUCATION	CIRCLE HIGHEST GRADE COMPLETED																
	GRAMMAR 1 2 3 4 5 6 7 8				HIGH 9 10 11 12				COLLEGE 1 2 3 4				GRADUATE 1 2 3 4				
		NAME	CITY	STATE	DID YOU GRADUATE?	MAJOR	DEGREE										
	HIGH SCHOOL																
	COLLEGE/ SCHOOL OF NURSING/ TECHNICAL																
OTHER SCHOOLING																	

CRIMINAL HISTORY	Are you the subject of a pending action or proceeding involving fraud or abuse in Medicare, Medicaid or other federal health care programs? Have you ever been sanctioned as a result of alleged Medicare, Medicaid fraud or abuse? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes to either question, please give details:	

	Have you ever been convicted of a crime (s)? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, give date(s) and details:	

I understand that disclosure of a criminal record will <u>not</u> automatically disqualify me from employment consideration.		

VOLUNTEER / EMPLOYMENT HISTORY	EMPLOYER		FROM	TO	POSITION AND DUTIES	REASON FOR LEAVING
	COMPANY NAME (Present/Most Recent)		MO / YR	MO / YR	POSITION	REASON FOR LEAVING
	STREET AND NO.				DUTIES:	
	CITY, STATE, ZIP CODE		TELEPHONE NO.			
	NAME AND TITLE OF IMMEDIATE SUPERVISOR					
	COMPANY NAME		MO / YR	MO / YR	POSITION	REASON FOR LEAVING
	STREET AND NO.				DUTIES:	
	CITY, STATE, ZIP CODE		TELEPHONE NO.			
	NAME AND TITLE OF IMMEDIATE SUPERVISOR					

CONTACT	IN CASE OF EMERGENCY PLEASE NOTIFY:		
	NAME	RELATIONSHIP	TELEPHONE NUMBER

SIGNATURE	I understand that falsification or omission of information on my application may result in my immediate dismissal.
	I understand that if accepted, I will (1) serve regularly as assigned; (2) accept supervision graciously; (3) agree to abide by all rules and policies of the Volunteer Service Department and the Medical Center; (4) attend necessary training and orientation; (5) consider confidential all information which comes to me in the performance of my duties; (6) wear the required uniform and ID badge; (7) return my identification badge and uniform when assignment is completed. I also attest to the fact that I am free of habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may adversely affect the performance of my duties. I also understand that failure to comply with hospital regulations will result in my dismissal from the volunteer program. I authorize investigation of all statements contained in this application and understand that this application is not and is not intended to be a contract of employment.
Applicant's Signature	Date

FOR OFFICE USE ONLY

Interviewed by _____	Has been/not been accepted _____		
Comments: _____ _____			
Area/Department _____	Days _____	Hours _____	Date Began Work _____
ID # _____	Medical Reference Completed and Checked _____	Orientation Completed _____	
Folder Completed _____	ID Returned _____	Last Day of Work _____	
Change of Assignment/Disciplinary Action/Resignation _____			
Additional Comments _____ _____			