San Gabriel Valley Medical Center

AHMC Healthcare

Date: _____

VOLUNTEER SERVICE APPLICATION FORM

(Please Print Clearly)

Name: _____

Address: _____City/Zip: _____

Phone: (___)_____ Date of Birth: _____

Check if under 18 years of age: _____ (must be at least 16 years old)

SS #:_____Email Address: _____

How did you hear about our hospital volunteer program? _____

Do you have previous volunteer service experience? If yes, please briefly describe below:

_____

Are you employed?____ If yes, work phone:_____

Are you a student?_____
School_____

Areas of interest, please circle the following:

Information Desk Nursing Floors Clerical Computer Surgery Waiting area

Maternity Pet Therapy Physical Therapy Emergency Dept.

Please indicate days. Circle the day(s) preferred:

Monday Tuesday Wednesday Thursday Friday Weekends

Please indicate times. Circle the time preferred:

Mornings Afternoons Evenings

Medical Contact Information

Person to call in emergency:_____

Relationship:_____Phone:_____

Do you have any physical limitations which would need to be accommodated when volunteering? Yes( ) No( )

If yes, explain:_____

If I am injured while volunteering at SGVMC, I give my consent for emergency treatment if needed.

Signature:_____Date:_____

If under 18, parent signature:_____
Date:_____

Names and phone number of two (2) references who have known you at least one year:

Name:_____Phone:_____

Relationship:_____

Name:_____Phone:_____

Relationship:
_____Phone:_____

Have you ever been convicted of any crime other than a minor traffic violation?

(Include misdemeanor and felony convictions) _____Yes _____No

If yes, please explain and state the charge._____

By signing below, you have stated that the above information is correct to the best of your knowledge.

Signature:
_____Date:_____

PLEASE SUBMIT COMPLETED APPLICATION TO THE INFORMATION DESK LOCATED IN THE HOSPITAL'S MAIN LOBBY