



Jewish Hospital

a century of excellence

100
1903 - 2003

Application Date _____

Adult Teen College

At which facility do you wish to volunteer?

- Jewish Hospital
- Outpatient Care Center

Last Name		First Name		MI	Nickname
Address			Apt. #		Home Phone
City			State		Zip
Birth Date	Month	Day			

Education and Work Experience

	Circle Last Grade Completed				
Employer	High School	9	10	11	12
Work Phone	College	1	2	3	4

Volunteer Work Preference

- Visitors/Families
- Direct Patient Contact
- Indirect Patient Contact
- Clerical Support Services
- Physical Therapy (College students only)
- Occupational Therapy (College students only)

Availability

Please check the boxes for the days and times you are most often available to volunteer.

	M	T	W	T	F
Morning					
Afternoon					

Emergency Contact

Name	Work Phone	Home Phone
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How did you hear about our Volunteer Program? _____

Signature _____ Date _____

FOR STUDENTS ONLY

School Presently Attending				Grade Level
Birth Date	Month	Day	Year	

IT IS VERY IMPORTANT THAT YOUR IMMUNIZATION RECORD IS ATTACHED TO THIS APPLICATION

**FOR STUDENTS UNDER 18 YEARS OF AGE
PARENT'S/LEGAL GUARDIAN'S AUTHORIZATION**

I hereby agree to allow _____ to serve as a
Name of Teen Volunteer Applicant
Teen volunteer at Jewish Hospital for such hours as are mutually agreed to by the Teen Volunteer applicant and those in charge of the program. I fully understand in the course of his/her duties, Teen Volunteer applicant may be permitted to enter patient areas of the Hospital.

In consideration of the opportunities extended to the Teen Volunteer applicant under the Teen Volunteer Program, I hereby release, remit, discharge, and relieve the Jewish Hospital HealthCare Services from any and all claims of whatever nature on behalf of the Teen Volunteer applicant arising out of and as a result of his/her service to Jewish Hospital HealthCare Services.

Date

Parent/Legal Guardian's Signature

FOR OFFICE USE ONLY

Date of Interview _____

Placement _____

Time _____

Orientation Date _____

Orient With _____



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CORRECT INCORRECT
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For Office Use Only - Group ID (optional)

[Grid of 25 empty boxes]

For Office Use Only - User ID (optional)

[Grid of 25 empty boxes]

For Office Use Only - Location / Store # (optional)

[Grid of 25 empty boxes]

First Name

[Grid of 10 empty boxes]

Middle Name or Initial

[Grid of 25 empty boxes]

Last Name

[Grid of 10 empty boxes]

Date of Birth (MMDDYYYY)

[Grid of 25 empty boxes]

Other Names Known By

Male

Female

[Grid of 10 empty boxes]

Social Security Number

[Grid of 10 empty boxes]

Primary Telephone Number (no dashes)

[Grid of 25 empty boxes]

Current Address

[Grid of 5 empty boxes]

Apt #

#yrs at this address

[Grid of 20 empty boxes]

City

[Grid of 3 empty boxes]

State

[Grid of 10 empty boxes]

Zip Code

[Grid of 25 empty boxes]

Previous Address

[Grid of 5 empty boxes]

Apt #

#yrs at this address

[Grid of 20 empty boxes]

City

[Grid of 3 empty boxes]

State

[Grid of 10 empty boxes]

Zip Code

[Grid of 20 empty boxes]

Driver's License Number (no dashes)

[Grid of 3 empty boxes]

License State

[Grid of 25 empty boxes]

Email Address

[Grid of 25 empty boxes]

Signature

[Grid of 10 empty boxes]

Today's Date (MMDDYYYY)

**No One Dies Alone
Compassionate Companion
Volunteer Agreement**

Name: _____

Address: _____

City: _____ State: _____ Zip Code _____

Home Telephone: _____ Work Telephone: _____

I am currently a:

- JHSMH Employee
- JHSMH Volunteer

The date of my last TB Test was: _____

I, the undersigned, am currently a JHSMH employee and/or a JHSMH volunteer. I understand I am offering my services as a *Compassionate Companion* in the role of a volunteer for the *No One Dies Alone* program. I understand I will not receive or expect compensation for my time and also understand I am in no way acting in my role as an employee of JHSMH and I will not perform or assist in any usual and customary patient care done by medical personnel. As a volunteer, I will have the ability to accept or decline requests to be a *Compassionate Companion* at my own discretion.

Signature _____ Date _____