AHMC Anaheim Regional Medical Center

AHMC Healthcare

Date: _____

VOLUNTEER SERVICE APPLICATION FORM

(CONFIDENTIAL INFORMATION)

Name: _____

Address: _____ City: _____

Zip: _____ Phone: _____

Check if under 18 years of age: ☐ (Must be at least 16 ½ years old to volunteer)

Date of Birth: _____ Email Address: _____

How did you hear about our hospital volunteer program? _____

Previous volunteer service? _____

Where_____

Community Services?_____ Where _____

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

Are you a student? _____ School _____

Areas of interest, please circle the following:

Information/Admitting Gift Shop Coffee Cart Patient Services

Clerical/Reception Magazine Cart Music Program Pet Assisted Wellness

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Days preferred, please circle the following:

Monday Tuesday Wednesday Thursday Friday Saturday

Time preferred, please circle the following and write hours available:

Morning _____ Afternoon _____

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Medical:

Person to call in emergency: _____

Relationship: _____ Phone: _____

Personal Physician: _____ 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 AHMC - ARMC, I give my consent for emergency treatment if needed.
Signature: _____ Date: _____

Names and addresses of two local references who have known you at least one year:

Name: _____ Phone: _____

Address: _____

Name: _____ Phone: _____

Address: _____

Maiden name or other names under which you have used _____

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, the court, the date and disposition of the case.
_____
_____

Upon receiving an offer of placement, a background check investigation may be required.

Signature: _____ Date: _____

Join our Volunteer Guild membership with annual dues of $10.00.