Volunteen APPLICATION

METHODIST VOLUNTEERS IN PARTNERSHIP

Date _____

Name _____
(Last) (First)

Legal Name (if different from above) _____

Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____

Current or Future High School _____ Grade _____

Birth Date _____ Age _____ Graduation Year _____

Parents'/Guardians' Names _____

Did someone refer you to the Methodist Volunteen Program? ☐ No ☐ Yes If yes, who referred you? _____

PERSONAL REFERENCE *This could be a coach, mentor or teacher.*

Name _____
(Last) (First)

Phone _____

Email _____

LOCATION PREFERENCE

☐ Methodist Hospital (MH) ☐ Methodist Women's Hospital (WH) ☐ Either Hospital

Please use this space to explain why you wish to become a Volunteen and what you expect to gain from this experience.

Do you currently volunteer at another area health care facility? ☐ No ☐ Yes

If so, what facility and what are your responsibilities?

In what other extracurricular activities (i.e. sports, show choir, debate, band, etc.) do you participate?

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IN CASE OF AN EMERGENCY, PLEASE NOTIFY:

Name _____ Relationship _____

Email _____ Phone _____

Family Physician _____

Address _____ Phone _____

PLEASE READ CAREFULLY BEFORE SIGNING

I understand that as a volunteer, I am expected to respect patient rights. One of the ways in which I will accomplish this is by not discussing, with anyone, the confidential information I may obtain through my assignment(s) at Methodist Hospital and/or Methodist Women's Hospital.

I understand that any false or incomplete statements on this application or any other form that I complete shall be sufficient cause for rejection for volunteer service or immediate discharge from volunteer service when discovered.

I understand that this application is not a contract of volunteer service. I understand that if I receive an offer to volunteer, it will be a conditional offer, expressly subject to safely meeting the mental and physical requirements of the volunteering opportunity, including a post-offer medical exam.

I understand if I am offered a volunteering opportunity, it will be contingent on successfully passing a post-offer drug test.

I understand that, if injured while volunteering, I/my insurance is responsible for any medical expenses related to this injury.

Signature _____ Date _____

PARENT/GUARDIAN CONSENT

I give consent for _____ to participate in the Methodist Volunteen Program.

Signature _____ Date _____

PLEASE RETURN APPLICATION TO YOUR PREFERRED VOLUNTEER LOCATION:

Volunteer Services, c/o Methodist Hospital, 8303 Dodge Street, Omaha, NE 68114 | 402-354-4533

Volunteer Services, c/o Methodist Women's Hospital, 707 N. 190th Plaza, Omaha, NE 68022 | 402-815-1130

THANK YOU FOR YOUR INTEREST IN THE METHODIST VOLUNTEEN PROGRAM.

Due to the large volume of Volunteen applications received, both hospital locations have Volunteen waiting lists. Please wait until a month before your 14th birthday to apply to the Volunteen Program.