

VOLUNTEEN APPLICATION



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 _____

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.

What will you bring to the program?

Did someone refer you to the Methodist Volunteen Program? No Yes

If so, who? _____

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?

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 Volunteer Program.

Signature _____ Date _____

PLEASE RETURN ALL APPLICATIONS TO OUR MAIN OFFICE AT:

Methodist Volunteer Services, 707 N. 190th Plaza, Omaha, NE 68022

Thank you for your interest in the Methodist Volunteer Program.

Due to the large volume of Volunteer applications received, both hospital locations have Volunteer waiting lists.

