

# APPLICATION FOR VOLUNTEER SERVICE

- AEMC
- MossRehab
- Willowcrest

\_\_\_\_/\_\_\_\_/\_\_\_\_  
TODAY'S DATE

\_\_\_\_\_  
(LAST NAME) (FIRST NAME)

ADDRESS: \_\_\_\_\_  
(STREET)

\_\_\_\_\_  
(CITY / STATE) (ZIP CODE)

TELEPHONE NUMBER: ( ) \_\_\_\_\_  
HOME SOCIAL SECURITY NUMBER

( ) \_\_\_\_\_  
BUSINESS

### IN CASE OF EMERGENCY, CONTACT:

NAME: \_\_\_\_\_

PHONE #: (HOME): \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_  
(WORK): \_\_\_\_\_

### VOLUNTEER EXPERIENCE:

(1) PLACE: \_\_\_\_\_ DATES: \_\_\_\_\_  
DUTIES: \_\_\_\_\_  
REFERENCES: \_\_\_\_\_  
(NAME) (POSITION) (PHONE #)

(2) PLACE: \_\_\_\_\_ DATES: \_\_\_\_\_  
DUTIES: \_\_\_\_\_  
REFERENCES: \_\_\_\_\_  
(NAME) (POSITION) (PHONE #)

### EMPLOYMENT EXPERIENCE:

(1) PLACE: \_\_\_\_\_ DATES: \_\_\_\_\_  
DUTIES: \_\_\_\_\_  
REFERENCES: \_\_\_\_\_  
(NAME) (POSITION) (PHONE #)

**Albert Einstein Medical Center**  
**Einstein**

(2) PLACE: \_\_\_\_\_ DATES: \_\_\_\_\_

DUTIES: \_\_\_\_\_

REFERENCES: \_\_\_\_\_  
(NAME) (POSITION) (PHONE #)

PRESENT EMPLOYMENT STATUS:  EMPLOYED  F-T  P-T  RETIRED  UNEMPLOYED

SPECIAL INTEREST: \_\_\_\_\_

SKILLS / TALENTS: \_\_\_\_\_

COMMUNITY INVOLVEMENTS: \_\_\_\_\_

EDUCATION: \_\_\_\_\_

WOULD YOU BE INTERESTED IN HELPING OUT AT SPECIAL EVENTS  
SUCH AS CULTURAL EVENTS, BLOOD DRIVE...ETC.  YES  NO

LANGUAGES SPOKEN \_\_\_\_\_

PERSONAL REFERENCES: (1) \_\_\_\_\_ (PHONE #)

(2) \_\_\_\_\_ (PHONE #)

**PLEASE CHECK OFF EACH AREA / TYPE OF VOLUNTEERING WHICH INTEREST YOU:**

- |                                   |  |  |
|-----------------------------------|--|--|
| <input type="radio"/> ADMISSIONS  | <input type="radio"/> FILING           | <input type="radio"/> NURSING                |
| <input type="radio"/> SPEECH      | <input type="radio"/> GIFT SHOP        | <input type="radio"/> THERAPEUTIC RECREATION |
| <input type="radio"/> CLERICAL    | <input type="radio"/> LIBRARY AIDE     | <input type="radio"/> PATIENT REPRESENTATIVE |
| <input type="radio"/> COPYING     | <input type="radio"/> MAIL / MESSENGER | <input type="radio"/> OCCUPATIONAL THERAPY   |
| <input type="radio"/> NUTRITION   | <input type="radio"/> HOSPITALITY      | <input type="radio"/> PHYSICAL THERAPY       |
| <input type="radio"/> ESCORT      | <input type="radio"/> MEDICAL RECORDS  | <input type="radio"/> RECEPTIONIST           |
| <input type="radio"/> OTHER _____ |  |  |

**PLEASE INDICATE THE DAYS AND TIMES WHEN YOU ARE AVAILABLE:**

- |                                   |             |           |
|-----------------------------------|-------------|-----------|
| <input type="radio"/> MONDAYS:    | FROM: _____ | TO: _____ |
| <input type="radio"/> TUESDAYS:   | FROM: _____ | TO: _____ |
| <input type="radio"/> WEDNESDAYS: | FROM: _____ | TO: _____ |
| <input type="radio"/> THURSDAYS:  | FROM: _____ | TO: _____ |
| <input type="radio"/> FRIDAYS:    | FROM: _____ | TO: _____ |
| <input type="radio"/> SATURDAYS:  | FROM: _____ | TO: _____ |
| <input type="radio"/> SUNDAYS:    | FROM: _____ | TO: _____ |

**PLEASE READ CAREFULLY AND SIGN:**

I understand that there is a three (3) month introductory period to determine whether the placement is appropriate for me and the department. At the end of this time I will meet with the Director of Volunteer and Chaplaincy Services or designee to discuss the continuation of the placement.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

I understand that in the event of any illness or injury resulting from my performing voluntary services at Einstein, I will be provided with appropriate medical care without cost, within the capabilities of the Medical Center. I will be seen in the Health Services Department for non-traumatic incidents and in the Emergency Room for traumatic ones.

If follow up care is needed, I will be seen by the appropriate out-patient service by arrangement of the Director of Volunteer & Chaplaincy Services or designee. In the event I wish to see a physician of my choice, I understand that I am responsible for the expenses incurred.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

I hereby give permission for the Volunteer & Chaplaincy Services Department to confer with my physician if and whenever deemed necessary.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

Doctor's Name \_\_\_\_\_

\_\_\_\_\_  
(PHONE #)

**PLEASE GIVE US YOUR REASONS FOR WANTING TO VOLUNTEER AT THIS TIME:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PLEASE RETURN COMPLETED APPLICATION TO EITHER:**

Volunteer & Chaplaincy Services  
Albert Einstein Medical Center  
5501 Old York Road  
Philadelphia, PA 19141  
(215) 456-6055

Volunteer & Chaplaincy Services  
MossRehab Hospital  
1200 West Tabor Road  
Philadelphia, PA 19141  
(215) 456-9527

**- TO BE COMPLETED BY INTERVIEWER -**

INTERVIEW DATE: \_\_\_\_\_ INTERVIEWER: \_\_\_\_\_

COMMENTS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

PLACEMENT CALLS: \_\_\_\_\_

TRAINING / SHADOWING: \_\_\_\_\_

BIRTH DATE: \_\_\_\_\_

MEDICAL INSURANCE CARRIER: \_\_\_\_\_

MEDICAL INSURANCE I.D. # \_\_\_\_\_

CONTACT PERSON: \_\_\_\_\_ EXTENSION: \_\_\_\_\_

**FOLLOW-UP:**

- |                                       |  |
|---------------------------------------|--|
| <input type="radio"/> Assignment Book | <input type="radio"/> New Volunteer List |
| <input type="radio"/> Log Book        | <input type="radio"/> Physical Exam      |
| <input type="radio"/> Master Card     | <input type="radio"/> I.D. Badge         |
| <input type="radio"/> Sign In Sheet   | <input type="radio"/> Computer           |
| <input type="radio"/> Rolodex File    | <input type="radio"/> Department Intro   |
|                                       | <input type="radio"/> Uniform Paid       |

	DATE	DATE	DATE
<b>VOLUNTEER ROLE</b>			
<b>DEPARTMENT</b>			
<b>SUPERVISOR</b>			
<b>SCHEDULE</b>			
<b>STARTING DATE</b>			