



**PROVIDENCE HOSPITAL**

VOLUNTEER SERVICES  
1150 Varnum Street, NE  
Washington, DC 20017

# VOLUNTEER SERVICE APPLICATION

**INTERNAL USE ONLY**

DATE APPLICATION RECEIVED _____	SCHEDULED INTERVIEW DATE _____	SCHEDULED ORIENTATION DATE _____
SERVICE AREA(S) _____	SCHEDULED DAY(S) & HOURS _____	

Providence Hospital Tel: (202) 269 - 7759  
Carroll Manor Tel: (202) 269 - 7719

**PERSONAL INFORMATION**

NAME: _____ ( First ) _____ ( Middle ) _____ ( Last )			DATE: _____
ADDRESS: _____ ( Number & Street )		( Apartment Number )	
_____ ( City )		_____ ( State ) _____ ( Zip )	
SOCIAL SECURITY #: _____	DATE OF BIRTH: _____	E-MAIL ADDRESS: _____	
TELEPHONE DAYS: _____ ( Area Code )	TELEPHONE EVENINGS: _____ ( Area Code )		
EDUCATION: _____ ( School Name ) _____ ( Location )			
<input type="checkbox"/> CURRENTLY A STUDENT <i>If "YES" &gt;&gt;</i> <input type="checkbox"/> FRESHMAN <input type="checkbox"/> SOPHOMORE <input type="checkbox"/> JUNIOR <input type="checkbox"/> SENIOR <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time			
EDUCATION COMPLETED:			
	SCHOOL NAME	DEGREE / MAJOR	
<input type="checkbox"/> HIGH SCHOOL	_____	_____	
<input type="checkbox"/> SOME COLLEGE	_____	_____	
<input type="checkbox"/> COLLEGE	_____	_____	
<input type="checkbox"/> GRADUATE SCHOOL	_____	_____	
<input type="checkbox"/> OTHER	_____	_____	
CURRENT EMPLOYER: _____ ( Position )		DATES: _____ ( From ) _____ ( To )	<b>PRESENT</b>
PREVIOUS EMPLOYER: _____ ( Position )		DATES: _____ ( From ) _____ ( To )	

**VOLUNTEERING INFORMATION**

LIST ALL PREVIOUS VOLUNTEER EXPERIENCE & DESCRIBE DUTIES:

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WHAT TYPE OF SERVICE WOULD YOU LIKE TO VOLUNTEER FOR AT **PROVIDENCE HOSPITAL**? ( check all that apply ) :

<input type="checkbox"/> PATIENT	<input type="checkbox"/> MAIL ROOM	<input type="checkbox"/> FILING ONLY	<input type="checkbox"/> FLOATER (Special Projects)
<input type="checkbox"/> BUSINESS OFFICE	<input type="checkbox"/> PRINT SHOP	<input type="checkbox"/> TYPING ONLY	<input type="checkbox"/> OTHER (Describe Below)
<input type="checkbox"/> MEDICAL SUPPLY	<input type="checkbox"/> INFORMATION DESK	<input type="checkbox"/> SECRETARIAL	_____

WHAT TYPE OF SERVICE WOULD YOU LIKE TO VOLUNTEER FOR AT **CARROLL MANOR**? ( check all that apply ) :

<input type="checkbox"/> ACTIVITY THERAPY	<input type="checkbox"/> EDUCATION	<input type="checkbox"/> MAINTENANCE	<input type="checkbox"/> UNIT CLERK
<input type="checkbox"/> ADMISSION	<input type="checkbox"/> FOOD SERVICE	<input type="checkbox"/> REHABILITATION	<input type="checkbox"/> OTHER (Describe Below)

WHAT DAYS & HOURS ARE YOU AVAILABLE TO VOLUNTEER?

WHAT DATE & TIME ARE YOU AVAILABLE TO START?

**VOLUNTEERING INFORMATION (Continued)**

ARE YOU WILLING TO ASSIST STAFF IN THE EVENT OF AN EMERGENCY?  NO  YES IF "YES", HOW LONG WOULD IT TAKE YOU TO GET TO THE HOSPITAL FROM HOME?  5 Minutes  15 Minutes  30 Minutes  45 Minutes  ≥ 1 Hour

PLEASE LIST ANY SPECIAL SKILLS / INTERESTS:  
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**REFERENCES / EMERGENCY CONTACTS / HEALTH STATUS**

LIST 2 ADULTS, WHO ARE NOT FAMILY MEMBERS, THAT CAN BE CONTACTED AS REFERENCES:

NAME	RELATIONSHIP	PHONE NUMBER
_____	_____	_____
_____	_____	_____

IN CASE OF EMERGENCY NOTIFY:

NAME	RELATIONSHIP	PHONE NUMBER
_____	_____	_____
_____	_____	_____

ARE THERE ANY HEALTH REASONS THAT MIGHT LIMIT YOUR ABILITY TO VOLUNTEER?  NO  YES (Describe) > > \_\_\_\_\_  
*A Physical Status Verification Form (provided by the VOLUNTEER SERVICES OFFICE) from your Doctor is required.*

**CONSENT**

**As a volunteer at PROVIDENCE HOSPITAL, I agree to:**

- 1. Commit to at least a 3 month term of volunteer service;
- 2. Be interviewed, photographed, videotaped and/or paraphrased for hospital Public Relations & promotional purposes;
- 3. Conduct myself with dignity, courtesy and respect towards others;
- 4. Produce the best quality of work possible;
- 5. Maintain confidentiality concerning all patients and healthcare business;
- 6. Be punctual and conscientious in the fulfillment of my duties. If I am late or absent for my assignment, I will notify my assignment supervisor and
- 7. Attend in-service meetings as scheduled when requested;
- 8. Refer assignment related questions, concerns and/or suggestions to my assigned supervisor first, and then to the Director of Volunteer Services;
- 9. Adhere to Providence Hospital's volunteer dress code;
- 10. Comply with all standards, policies, procedures and values of Providence Hospital, the Department(s) that I am performing volunteer work for, and Volunteer Services Department; and
- 11. Obey all applicable District of Columbia & Federal laws.

I understand that documentation of my service will be released upon request only after the minimum 3 month term of service has been completed. I certify that the information contained in this volunteer application is true, correct and complete to the best of my knowledge. I authorize the Volunteer Services Department to make relevant inquiries pertaining to all statements made in this volunteer application. I understand that this information shall remain confidential.

\_\_\_\_\_  
SIGNATURE OF APPLICANT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
(If Applicant <18 Years Old) SIGNATURE OF PARENT / GUARDIAN

\_\_\_\_\_  
DATE

*Thank You for Volunteering at PROVIDENCE HOSPITAL !*