Hackensack Meridian
Mountainside Medical Center

Adult Volunteer Application Form

Please Check: Miss ____ Mrs. ____ Ms. ____ Mr. ____ Mx.____ **Date**: ___/_____/_____

Name: _____ **SSN:** ___/_____/_____

Full Address: _____

_____

Home Phone: (_____) _____ - _____ **Cell Phone:** (_____) _____-_____

May we contact you at work? □ Yes □ No **E-Mail Address:** _____

Work Phone #_____

Birth Date: ____/_____/_____ **(Year optional)**

Physical Limitations/Disabilities: □ Yes, please explain _____ □ No

Current Status: □ Student □ Employed □ Unemployed □ Retired

Employed By: _____

Occupation (past/present): _____

Interests/Skills:

□ Typing/word processing □ Clerical/non-typing □ Computer

□ People skills □ Record keeping □ Mailings

□ Other, please list: _____

Foreign Languages: _____

Volunteer Experience: _____

Volunteer Work Preference:

□ Patient contact □ Non-patient contact □ Clerical

□ Other (please list): _____

Availability Days: _____ **Availability Times:** _____

Are you available throughout the year? If no, when are you available? _____

_____

Personal Reference: (please exclude relatives)

_____
Name Telephone

_____
Street Address Town State Zip

Personal Physician:

_____
Name Telephone

_____
Street Address Town State Zip

In an emergency, notify:

_____
Name Cell Phone

_____
Business Phone Relationship

Are you required to volunteer? ___ Yes ___ No **If yes, how many hours? _____**

Have you previously volunteered for Hackensack Meridian Mountainside Medical Center?

_____

How did you hear about Hackensack Meridian Mountainside Medical Center Volunteer Program?

_____

_____

Please give any other information you feel is pertinent to your application: _____

_____

_____

_____

The above information is accurate and correct to the best of my knowledge. I authorize Hackensack Meridian Mountainside Medical Center to conduct a thorough background check that may include a police or reference check.

_____ _____

Signature **Date**