VOLUNTEER APPLICATION

CONTACT INFORMATION

First and Last Name	
Street Address	
City, State, Zip Code	
Home Phone	
Cell Phone	
Student ☐YES ☐NO	*Student Availability (Semester)* ☐ FALL ☐ SPRING ☐ SUMMER
College or University	
E-Mail Address	
Preferred Contact Method	☐ Home Phone ☐ Cell Phone ☐ Email

AVAILABILITY

During which hours are you available for volunteer assignments?

___ Weekday mornings
___ Weekday afternoons
___ Weekday evenings

___ Weekend mornings
___ Weekend afternoons
___ Weekend evenings

INTERESTS

Please check all areas of interest

___ Patient Contact
___ Non Patient Contact
___ Clerical
___ Outpatient Laboratories
___ Admissions/Information
___ Nutrition and Dining
___ Gift Shop
___ Fundraising
___ Cancer/Infusion Services
___ Long Term Rehabilitation Unit (PMRU)

___ Information/Phones
___ Pharmacy
___ Emergency Room
___ Patient Ambassador
___ Behavioral/Mental Health Services
___ Radiology Services
___ Other (Please Specify)
____

___ SHADOWING**
***Individuals must complete 40 Volunteer hours prior to shadowing and seek approval of practitioner*
___ Pet Therapy (PAWS)*
**Your dog's certification through PAWS Required – ask for details*
___ Physical Therapy**
(must be enrolled in a College PT/Sports Medicine Program)

SPECIAL SKILLS OR QUALIFICATIONS

Summarize special skills and qualifications you have acquired from employment, previous volunteer work, or through other activities:

PREVIOUS VOLUNTEER EXPERIENCE

Summarize your previous volunteer experience, healthcare or otherwise:

WHY CAYUGA MEDICAL CENTER?

Summarize what interests you about volunteering for Cayuga Medical Center:

SPECIAL INTERESTS

Summarize what areas you would like to be a part of during your volunteer experience:

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name	
Street Address	
City, Sate, Zip Code	
Home Phone	
Work or Cell Phone	
E-Mail Address	
Preferred Contact Method	□ **Home Phone** □ **Cell Phone** □**Email**

AGREEMENT AND SIGNATURE

By submitting this application, I affirm that the facts set forth in it are true and complete. I understand that if I am accepted as a volunteer, any false statements, omissions, or other misrepresentations made by me on this application may result in my immediate dismissal.

Name (printed)	
Signature	
Date	

OUR POLICY

It is the policy of this organization to provide equal opportunities without regard to race, color, religion, national origin, gender, sexual preference, age, or disability.

Thank you for completing this application form and for your interest in volunteering at Cayuga Medical Center.

OUR CONTACT INFORMATION

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