Children's HOSPITAL & MEDICAL CENTER

We know children.

Volunteer Application

Children's Hospital & Medical Center
Volunteer Services
8200 Dodge Street
Omaha, NE 68114
(402) 955-4012

PERSONAL INFORMATION

Name: _____ Today's Date: _____
Last First MI

Address: _____ Preferred method of contact: _____
Street City State Zip

Day Time Phone: _____ Cell Phone: _____ E-mail Address: _____

Emergency Contact

Name: _____ Day Phone: _____ Evening/Weekend Phone: _____

Other Information

Previous volunteer experience at Children's? Yes____No_____ Year: _____
Other hospital? _____What Areas? _____

Other volunteer experience: _____

_____

Hobbies, Skills or Special Interests, please complete: _____

_____

If you need verification of your volunteer hours include the name and address of your organization: (i.e. church, civic organization) _____

How did you learn about Children's Hospital & Medical Center volunteer opportunities? _____

_____

Additional information or comments: _____

_____

_____

Indicate your preferred day(s) and time(s) to volunteer.

	Monday - Friday	Saturday & Sunday
Morning		
Afternoon		
Evening		

Service area interest:

A. _____

B. _____

C. _____

VOLUNTEER STATEMENT OF COMMITMENT: I understand that my services are donated to Children's Hospital & Medical Center and that there is no payment for the services rendered under the volunteer program. I understand that volunteering at Children's means a commitment to a specific program and service activities. I understand that staff, patients, and families will depend on me. I understand that if I am unable to attend my shift this will create extra work or reorganization by others instead of helping those who rely on me.

CONFIDENTIALITY AGREEMENT: *I understand that any information that I may obtain directly or indirectly concerning patients, families, visitors, staff, Children's Hospital & Medical Center, or affiliates will be held absolutely confidential. If I break confidentially of patients and/or families I may be terminated from the volunteer program.*

ANNUAL TB SKIN TEST and EDUCATION REVIEW: I understand that I am responsible to complete an annual TB skin test and education review of hospital and service area information.

PHOTO RELEASE: I understand that a hospital representative may take photographs of me for publications or volunteer services use during my volunteer time.

I have read the above statements. I understand the written information and agree to abide by the rules, regulations and policies of Children's Hospital & Medical Center, affiliates, and the Volunteer Services Department. I understand that if I do not abide by rules, regulations and policies I may be terminated from the volunteer program.

_____ _____

Volunteer Signature Date

Complete if you are a current COLLEGE STUDENT:

Secondary address: _____

Address Phone

Parent / guardian: _____

Name Address Phone

School Attending: _____ Current year: _____ Expected graduation date: _____

Do you need verification of volunteer hours and/or activity? ☐ Yes ☐ No If yes complete information below:

_____

School and Department Contact Name Title

_____

Street City State Zip Email

Note*: Documentation form must be provided to Volunteer Services prior to volunteering*