

LAKE TAYLOR

TRANSITIONAL CARE HOSPITAL

VOLUNTEER APPLICATION

(Applicant's Name - Last, First, Middle)	Birthday	Soc. Sec. No:
(Home Address)	(City)	(Zip)
		Home Ph. # Office #:

Education: _____

Experience: (Volunteer & Paid Work) _____

Special Skills: _____

Special Interests & Hobbies: _____

My address and phone number may be distributed to other volunteers Yes No

ENTER DAYS AND HOURS AVAILABLE				Physician Name: _____ Address: _____ Phone: _____ P.P.D. results within the last year: Date: _____ Results: _____
	Morning	Afternoon	Evening	
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

Name & Address of Person to Contact in Case of Injury or Illness While on Duty Phone #

List Two Personal References (Give Name, Address, Zip) Phone #

Phone #

How Did You Learn of Our Volunteer Program?

I, the undersigned applicant, certify that all statements made in this application are true, to the best of my knowledge and belief, and I hereby give permission for the verification of same, as deemed necessary by the Department Head.

Applicant's Signature

Date