Carla Young
Volunteer Services
679-6253 or 679-5980

MASONICARE HEALTH CENTER

APPLICATION FOR JUNIOR VOLUNTEERS

Date: _____

Name: _____Phone #: ( )_____ E-mail: _____

Address: _____
Street City State Zip Code

Date of Birth: _____ School you attend _____ Class of _____
Month Day Year

What day each week will you be available for volunteer service? _____

Name of relative(s) working here (state relationship): _____

_____

Are you interested in a career in the health care field?

- ☐ Medicine/Nursing
- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ Recreational Therapy

Please list your interests and hobbies: _____

_____

List any previous volunteer work: _____

List any major illnesses within the last five years: _____

Do you have any physical condition(s) that would prevent you from performing certain types of work? ____

_____

Person to contact in case of emergency: _____-
_____
Name Phone #

Reference: _____
Name Address

For Office Use Only

Orientation: _____ ID (Photo) Badge:_____

PPD Test: _____ Computer Entry: _____

Starting Date: _____ Assignment: _____

web