

**PERSONAL INFORMATION**

/ /				
<b>Name:</b> ↑	<u>Last</u>	<u>First</u>	<u>Middle</u>	<u>Date of Birth</u>
<b>Address:</b> ↑	<u>Street &amp; No.</u>	<u>Apt. #</u>	<u>City/Town</u>	<u>State</u> <u>Zip</u>
<b>Home Phone #</b> ↑	<b>Cell Phone #</b>		<b>Email:</b>	
<b>In case of emergency, whom should we contact?</b>				
<b>Name:</b> ↓	<b>Relationship:</b>		<b>Phone:</b>	
			(   )	

**TELL US ABOUT YOURSELF**

**Would you like to work with residents?**  
 Yes    No

**What departments or programs are you interested in?**  
 \_\_\_\_\_  
 \_\_\_\_\_

**Day(s) you are available to volunteer (circle)**  
 Mon   Tue   Wed   Thurs   Fri   Sat   Sun

**Times Available:**  
 Morning   Afternoon   Evening   Full Day

**Are you interested in a career in the health care field?**  
 Yes    No

**If yes, what area (Circle):**  
 Medicine/Nursing   Occupational Therapy  
 Physical Therapy   Radiology  
 Recreational Therapy   Other \_\_\_\_\_

**Do you have any special talents?**  
 Art   Dance   Photography   Organize   Nails  
 Play Instrument(s)   Sing   Working with Children  
 Other: \_\_\_\_\_

**Do you speak another language?**    Yes    No  
**If yes, what language(s)?** \_\_\_\_\_

**Do you have a relative who works here?**  
 Yes    No   **If yes, who & where?** \_\_\_\_\_

**Do you have any physical, mental, or medical condition which would prevent you from performing certain types of work?**  
 Yes    No   **If yes, please describe:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Are you required to perform community Service?**    Yes    No  
**If Yes, Please check appropriate Box:**  
 Pre- CNA  
 College or Educational Requirements  
 Court- Ordered

**How Many Hours do you need to complete?** \_\_\_\_\_   **When are these hours Due by?** \_\_\_\_\_

## EMPLOYMENT OR VOLUNTEER EXPERIENCE INFORMATION

Please list recent work or volunteer position you have held. Include your supervisor's name.

If you have never worked or volunteered, please go to the next section:

<b>Employer / Previous Volunteer Org.:</b> ↓ _____ _____ _____	<b>Dates / From - To:</b>  From: _____  To: _____	<b>Position:</b> _____  <b>Duties:</b> _____ _____ _____
<b>Address:</b> _____ _____	<b>City/State:</b> City _____ State _____	<b>Reason for Leaving:</b> _____ _____
<b>Name and Title of Supervisor:</b> _____	<b>Phone #:</b> (     )	<b>May we contact him/her?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No

## EDUCATION INFORMATION

<b>What High School did you attend?</b> _____	<b>City/State:</b> _____
<b>What College or Universities do or did you attend?</b> _____	
<b>City/State:</b> _____	<b>Major?</b> _____
<b>Did you graduate?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If Yes, What year?</b> _____	
<b>Have you earned Any Certifications, Licenses, Degrees or attended any other Schooling:</b> _____ _____ _____	

**Why are you interested in volunteering at Masonicare Health Center?**

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- I have answered each question fully and correctly.
- I agree to respect the rights and confidentiality of the residents and patients.
- I understand I am volunteering on my own free will, and understand the responsibilities and commitment I will have to make.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_