HAWAIʻI PACIFIC HEALTH | KAPIʻOLANI PALI MOMI STRAUB WILCOX

WILCOX MEDICAL CENTER

Volunteer Services • 3-3420 Kuhio Highway • Lihue, Hawaii 96766-1099 • Phone: (808) 245--1144 • Fax: (808) 245-1475

ADULT VOLUNTEER APPLICATION

GENERAL INFORMATION

Name:_____ Birthday:_____
Last First MI Month/Day

Address:_____ City:_____ Zip:_____

Phone (Home):_____ (Work/Cell)_____

E-mail Address: _____

Emergency Contact Person: _____

Relation:_____ Phone:(H)_____ (B)_____

Physician Name:_____ Phone:_____

Have you ever been convicted of a felony? Yes __ No __ If yes, explain when, where, type of offences and disposition of case. (A conviction will not necessarily disqualify application from the position applied for.)

AVAILABILITY

What are the days/times you are available to volunteer? Please check below:

(Minimum 4 hrs. a week; a consecutive 4-hour shift or two 2-hour shifts.)

8/8:30a.m. - Noon/12:30p.m.

Mon ❑ Tues ❑ Wed ❑ Thu ❑ Fri ❑ Sat ❑ Sun ❑

Noon/12:30p.m. - 4/4:30p.m.

Mon ❑ Tues ❑ Wed ❑ Thu ❑ Fri ❑ Sat ❑ Sun ❑

4:30/5:00p.m. - 8:30/9:00p.m.

Mon ❑ Tues ❑ Wed ❑ Thu ❑ Fri ❑ Sat ❑ Sun ❑

Can you commit to a regular schedule? ❑ Yes ❑ No

DO NOT WRITE BELOW – FOR VOLUNTEER OFFICE USE ONLY

Date Rec'd:_____ Interview Date:_____ Orient.Date:_____

Assign:_____ Day(s)_____ Time: _____Start Date:_____

Assign:_____ Day(s)_____ Time: _____Start Date:_____

HEALTH RECORDS: TB: (1)_____(2) _____**or** +PPD_____mm_____& X-Ray_____

MMR_____ Varicella_____ Flu___ For HT/RT only: Hep B Titre__or Hep B Series; #1__#2__#3__.

BG Ck submitted: _____ BG Ck Received: _____ N.O.L: _____

Comments:

TYPES OF ASSIGNMENTS YOU ENJOY

- ❑ Patient Escort
- ❑ Running Errands
- ❑ Book Cart
- ❑ Gift Shop
- ❑ Reading to Patients
- ❑ Patient Greeter/Visitor Assistant/Hospitality
- ❑ Arts & Crafts with Patients (Kapi`olani Medical Center for Women & Children only)

OTHER INFORMATION

Current Employer: _____ Position/Title: _____

School: _____ Major: _____

Work experience (paid or volunteer): _____

_____

Career/special interests, hobbies, skills: _____

_____

List special training or noteworthy achievements: _____

_____

Why do you want to volunteer? _____

_____

Future Objectives _____

REFERENCES

Name three individuals (not related) who have knowledge of your qualifications and whom we have permission to contact immediately, preferably individuals under whom you have worked.

Name	Title/Occupation	Where Employed	Phone Number

I certify that all statements made in the application are true. I understand that if selected for a volunteer position, falsified statements on this application or failure to furnish all requested information shall be considered sufficient cause for my dismissal from the volunteer program. I agree to a criminal background and reference check. I agree to abide by the policies and regulations of Hawai`i Pacific Health and its Volunteer Program.

Signature: _____ **Date:** _____

Please sign and submit this application to:

Wilcox Medical Center
Volunteer Services Department
3-3420 Kuhio Highway
Lihue, Hawaii 96766
(808) 245-1144

The application process must be completed within three months of the date of receipt. If you have been notified of incomplete information and have not contacted the volunteer office, your application will be removed.