

Volunteer Application

Please indicate your first and second preference for hospital:

<input type="checkbox"/> University Hospital (614) 293-8653 155 Doan Hall 410 W. 10 th Ave. Columbus, OH 43210 Fax: (614) 293-9182	<input type="checkbox"/> James Cancer Hospital (614) 293-4663 Suite 114 300 W. 10 th Ave. Columbus, Ohio 43210 Fax: (614) 293-5919	<input type="checkbox"/> University Hospital East (614) 257-3155 1492 E. Broad St. Columbus, OH 43205 Fax: (614) 257-2015	<input type="checkbox"/> Ross Heart Hospital (614) 293-7870 Room H1245 452 W. 10 th Ave. Columbus, OH 43210 Fax: (614) 293-9182
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Name _____			Date _____		
(Last)	(First)	(Middle)			
Address _____			_____		
(Street)		(City)	(State)	(Zip)	
Home Phone _____		Work Phone _____		Mobile Phone _____	
Email Address _____			Date of Birth _____		
Do you have a Social Security Number? <input type="checkbox"/> Yes <input type="checkbox"/> No					

How did you become interested in our Volunteer Program? _____

What do you hope to gain from your volunteer experience? _____

Have you ever volunteered for or been employed by the OSU Medical Center? Yes No

Volunteer Experience: _____

Current or Last Employment:

Employer's Name: _____ Dates of Employment: _____

Occupation (Type of work): _____ Work Hours: _____

May we call you at work? Yes No Best time to call: _____

Have you ever been terminated from volunteering or a paid position? Yes No

Person to be notified in case of emergency: _____

Relationship _____ Phone (____) _____

Please indicate which days and times you are available:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

How long have you been a resident of Ohio? _____ Are you a year-round resident? Yes No

If not a year-round resident, what months are you available? _____

Do you have any health limitations? Yes No

If yes, please describe: _____

Education:

Highest level completed: _____ Degree/Major: _____

High School/College: _____ Date of Graduation: _____

References: must be over 21 years of age, have known you for at least 2 years, and only one may be a relative

1. Name: _____ Relationship: _____ Phone: (____) _____

Email or Street Address: _____ City: _____ Zip: _____

2. Name: _____ Relationship: _____ Phone: (____) _____

Email or Street Address: _____ City: _____ Zip: _____

Medical Reference (Primary care physician or specialist):

Name: _____ Phone: (____) _____

Address: _____ City: _____ Zip: _____

Background Checks:

We consider the safety and security of our patients to be of the utmost importance. We will conduct at our cost a criminal background check with state and/or federal agencies.

Have you ever been convicted of a felony or misdemeanor offense? Yes No

If yes, you must provide details. A conviction will not necessarily bar you from volunteer service. Please use this space to describe the offense: _____

Confidentiality Statement

I will consider as confidential all information that I may gain in my volunteer position, directly or indirectly, concerning patients, doctors, staff, employees, families, and volunteers. I understand that my volunteer service will be terminated as a result of any breach of confidentiality.

Applicant's Signature: _____ Date: _____

The above information is accurate and correct to the best of my knowledge. I understand that The OSU Medical Center is not responsible for illness or injuries encountered during my volunteer service, or for payment to physicians or the Emergency Department resulting there from. My signature gives my approval for The OSU Medical Center to check references, perform a background check and contact my physician regarding my physical and emotional health. The OSU Medical Center is not obligated to provide placement, nor am I obligated to accept the position offered. I understand that the only way to receive paid employment is to apply through the Office of Human Resources for The Ohio State University.

Opportunities for Volunteers are provided without regard to religion, creed, race, national origin, age, or sex.