VOLUNTEER APPLICATION

Date: _____

Last Name: _____ **First Name**_____ **Middle Initial**_____

Date of Birth_____**Age - Under 18 years** ____ **Over 18 years**___

Address:_____**City**_____**State**_____**Zip**_____

Home Phone:_____**Cell Phone:**_____**Bus. Phone:**_____

Email Address:_____ **Shirt Size:**_____

Language Skills:_____ **Computer Skills:**_____

Special Skills:_____

Emergency Contact:

Name:_____ **Relation:**_____

Emergency Contact Phone Number:_____

Availability

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
AM							
PM							
EVE							

Please indicate hours and time

How were you referred to the Volunteer program:_____

If employee referral, list the employee name:_____

I agree to abide by all policies and procedures of the Volunteer Department and those of Broward Health.
I agree to complete all required orientation and trainings as needed.

Signature_____ Date:_____

Broward Health

Volunteer Medical Clearance

To be completed by applicant

Name: _____Date of Birth:_____ Last 4 digits of SS#_____

Address:_____City_____Zip_____

Phone:_____

I understand that providing documentation of the health information below is a condition of being permitted to volunteer at a Broward Health Facility. I authorize, my physician,

_____, to provide such documentation and to provide any vaccines and/or TB skin tests necessary to complete my orientation requirements.

Applicant Signature_____ Date:_____

If Applicant is under 18 years of age, parent or legal guardian signature is required.

Parent/Guardian _____Print Name:_____

To be completed by Physician: _____ (Printed Name)

Due to infection control policies, volunteer applicants for (enter Medical Center)_____, must provide documentation of compliance for the following (copies may be attached to this form).

- **Chicken Pox. Has the applicant had chicken pox? No___ Yes___**
- **If yes, date of disease_____ OR date of positive titer _____attach lab report**
- **If no, provide documentation of vaccination (2 doses of varicella) _____date of first dose, Date of second dose_____ .**
- **TB tests - recent skin tests within 6 months. Chest X Ray required for a positive history of positive skin tests.**
- **If the applicant had a TB skin test within the past 12 months, another skin test is required no more than 30 days prior to volunteering.**
- **Date of TST _____Date read_____ Results (in mm)_____ attach result**
- **IF applicant has had a positive skin test, what was the date_____. He/She will need a Chest X Ray within 6 months. IF there was a significant reaction, was a chest X Ray taken Y N. Date of XRAY _____attach results. Was INH provided for treatment Y N, If Yes, Dates of Treatment_____.**

Is applicant able to ambulate more than 1500 feet independently Y N

If no, can the applicant ambulate with assistive devices Y N

Specify device and/or any restrictions; _____

Certification:

The applicant to my knowledge does not have any medical or cognitive condition what would affect their ability to perform volunteer duties within a hospital or office setting. The above information has been provided by me, the undersigned.

Signature of Practioner_____Title_____Date_____

Printed Name of Practitioner_____

Location of Practice

Address_____City_____Zip_____

Phone: _____