



**ADULT PROGRAMS VOLUNTEER APPLICATION**

The Hospital is an Equal Opportunity/Affirmative Action employer seeking qualified candidates regardless of race, religion, color, sex, age, marital status, national origin, gender preference, mental handicap or veteran's status, in conformity with applicable laws. This application is active for six months. If you have not been selected within six months and wish to remain in consideration for a volunteer position, you must reapply. **Please print responses to all questions below:**

**Date of Application:**

|  |             |   |
|--|-------------|---|
| Last Name:   | First:      | MI:   |
| Home Phone:  | Cell Phone: |   |
| E-mail Address:  |             |   |
| Street Address:  | City:       | State: Zip Code:  |
| Are you eligible to work in the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No |             | Are you under the age of 18? <input type="checkbox"/> Yes <input type="checkbox"/> No |

**In what environment would you be most comfortable working?**

- Child Life (assist staff with age appropriate play activities for patients and siblings)
- Hospital School Program (tutoring patients/assisting with schoolwork)
- Hospitality (providing information and assistance to patients and families)
- PT or OT**
- Musicians On Call
- Reach Out and Read (reading to patients and siblings in waiting areas of CHOP Care Networks)
- Paw Partners Pet Therapy Program
- College Student Looking for summer only (Hospitality or Reach Out and Read only)
- Other: (Please specify interest) \_\_\_\_\_

How did you learn about our volunteer programs?  CHOP website  CHOP Employee/Volunteer  School/College  
 Other Specify Name of Referral Source: \_\_\_\_\_

| EDUCATION   | High School  | College/University                                       | Graduate/Professional                                    | Trade or Business  |
|---|--|--|--|--|
| School Name & Address                                 |  |  |  |  |
| No. of Years Completed                                |  |  |  |  |
| List Major Course of Study                            |  |  |  |  |
| Did You Graduate?                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| List diploma/degree/ highest achievement/Year awarded |  |  |  |  |

Describe abilities, experience, special skills, languages and other qualifications, which may qualify you for the position for which you are applying.

**AVAILABILITY (3 hour shift)**  
Mornings(9am-12pm) \_\_\_\_\_ Afternoon(12-4) \_\_\_\_\_ Evenings(4-9) \_\_\_\_\_

Circle Day(s)    Monday   Tuesday   Wednesday   Thursday   Friday   Saturday   Sunday

**PERSONAL REFERENCE (no relatives please)**

Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Email Address: \_\_\_\_\_

Have you had previous experience working with children in any capacity? If so, please describe.

\_\_\_\_\_

**PREVIOUS VOLUNTEER EXPERIENCE**

1. Organization \_\_\_\_\_ Dates: \_\_\_\_\_  
City/State: \_\_\_\_\_  
Duties \_\_\_\_\_

2. Organization \_\_\_\_\_ Dates: \_\_\_\_\_  
City/State: \_\_\_\_\_  
Duties \_\_\_\_\_

Please state briefly the reason(s) why you desire to become a member of the volunteer program at The Children's Hospital of Philadelphia.

\_\_\_\_\_

Are you able to perform the duties of the job for which you are applying?  Yes  No

Are you a current CHOP Employee?  Yes  No If yes, please supply the following information:

Department \_\_\_\_\_ Date of hire: \_\_\_\_\_

Direct Supervisor's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Is your direct supervisor aware that you are applying to become a CHOP volunteer?  YES  NO

Are you currently or have you ever been on Counseling in regards to your job?  YES  NO

If yes, please explain: \_\_\_\_\_

Have you applied previously to CHOP?  Yes  No  
If yes, when? \_\_\_\_\_

Have you ever been employed at CHOP?  Yes  No  
If yes, reason for leaving: \_\_\_\_\_

Is any family member a CHOP employee?  Yes  No  
Name of family member: \_\_\_\_\_

Are you known to anyone, anywhere by another name?  
 Yes  No  
If Yes what name(s)? \_\_\_\_\_

Do you have commitments to another employer, school hobby, etc that might affect your volunteer commitment at CHOP?  Yes  No  
If yes, explain: \_\_\_\_\_

\_\_\_\_\_

**AGREEMENT**

I certify that the information provided on this application is true and complete to the best of my knowledge, and agree that falsified information or significant omissions may disqualify me from further consideration for volunteering and, if I am accepted to be a volunteer, will result in my dismissal when discovered. I understand that, if accepted as a volunteer, I will be required to abide by all of the policies, rules and regulations of the Hospital. I authorize the Hospital to investigate all statements contained in this application and to make inquiries of my personal reference and medical history, as well as other related matters as may be necessary for arriving at a decision of acceptance into the volunteer program. I hereby release employers, schools or individuals from all liability in responding to inquiries relative to my volunteer application.

Signature of Applicant \_\_\_\_\_

Date \_\_\_\_\_



