

Volunteer Application



McLean Hospital, 115 Mill Street, Belmont, MA 02478

Phone: 617.855.2118

Email: cgbrown@partners.org

Date: _____

Name: _____

Street address: _____

Permanent address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____

Cell phone: _____ Email address: _____

Date of Birth (optional): ___/___/___

In an emergency, notify: _____ Relationship: _____ Phone: _____

EDUCATION:

High School: _____ Year of Graduation: _____

College: _____ Year of Graduation: _____

Area of Study: _____ Degree: _____

Graduate School: _____ Degree: _____

EMPLOYMENT:

1. Present/last employer: _____ From: _____ To: _____

Position held: _____ Reason for leaving: _____

2. Previous employer: _____ From: _____ To: _____

Position held: _____ Reason for leaving: _____

Foreign languages spoken fluently: _____

REFERENCES: Please list two persons other than relatives.

Name: _____ Address: _____ Phone: _____

Name: _____ Address: _____ Phone: _____

VOLUNTEER EXPERIENCE: List names and addresses of all volunteer experiences

1. _____

2. _____

Have you ever been an employee at McLean Hospital? _____ Yes _____ No

When are you available to volunteer?

	Morning	Afternoon	Evening
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			

Your volunteer assignment must take place during the standard work week (Monday-Friday, 8am-5pm).

How many times per week would you like to volunteer? Once _____ 2-3 times _____

Why do you want to volunteer at McLean Hospital? _____

INTEREST/SKILLS:

Please list all useful volunteer skills:

Additional comments/skills:

For applicants 16 years of age or younger parental signature is required. Parental consent will be required prior to the processing of your application.

PLEASE CHECK _____ 16-17* _____ 18 and over _____
(*Needs written parental consent)

Are you doing this for _____ course credit _____ community service?
If yes, how long and/or how many hours? _____

Contact person at school/community center/other: Name: _____
Phone: _____

Signature of Parent or Guardian: _____

Please print name and address and telephone number: _____

The above information is accurate and correct to the best of my knowledge. I will uphold the traditions and standards of McLean Hospital. I will endeavor to do my best to give volunteer service of the highest quality. I will consider as confidential all information which I may hear directly or indirectly concerning a patient, doctor or any member of the personnel and will not seek information in regards to a patient.

By checking this box, I hereby authorize the use and reproduction by McLean Hospital of any and all photographs or video taken of me for the purpose of general marketing communications, promotion, or advertising, without compensation to me. All photographs and video shall constitute the property of McLean Hospital

I have received, read, and understood and will follow the McLean Hospital Guidelines for Volunteers.

Signature: _____

Your signature indicates your approval for us to check references. Opportunities for volunteers are provided without regard to religion, creed, race, national origin, age, or sex.

You may not begin volunteer service until you have completed the volunteer process. This includes Orientation (McLean Hospital), a TB test, a CORI, and an orientation with the Coordinator of Volunteer Services. You will receive a time sheet in which you must record your hours worked and have it signed by your supervisor at the time of termination. At the time of termination you must return your badge to Volunteer Services. Please notify **the Volunteer Department at 617.855.2118** or email cgbrown@partners.org when you have completed service.

You **must wear your Volunteer badge at all times**. Volunteers are not allowed to have keys, cannot be alone with patients, and must have supervision. Each volunteer must have a volunteer request form (volunteer job description) on file in the volunteer department.