



Date: _____

VOLUNTEER SERVICE APPLICATION

Last Name _____ First Name _____
Address _____ Home Phone _____
City/State/Zip _____
E-Mail _____ Cell Phone: _____
Date of Birth _____
Mo./Date/Yr

EMPLOYER:

Name: _____
Address _____
Phone _____
City/State/Zip _____

College/University Student

Name of School _____
Campus: _____

In Case of Emergency/Illness

Contact: _____
Relationship: _____

Phone:

Cell _____
Home: _____
Business: _____

Why are you interested in our volunteer program?

Please list any prior volunteer experience:

EDUCATION: Last year completed, degree: _____

LANGUAGES: What languages do you speak? _____

VOLUNTEER PREFERENCES:

Patient care services Yes _____ No _____
Office Services Yes _____ No _____
Other Interests: Please List

References: Two references are required: (One personal, one business, not family member)

Please have references sent to:

Denise Whitley
Coordinator of Volunteer Services
7600 River Road
North Bergen, NJ 07047
Fax: (201) 854-5748
Email: dwhitley@palisadesmedical.org

Have you ever been convicted of a crime? _____ If yes, explain when, where and disposition of case _____

Availability: Please note hours available in appropriate spaces.

	Sunday	Monday	Tuesday	Wednes	Thurs.	Friday	Sat.
Time Available							

(Actual commitment time will be determined during interview with the Coordinator of Volunteer Services)

I agree to abide by the requirements and regulations of Palisades Medical Center and the service to which I am assigned. I will serve a minimum of eighty (80) hours after participating in required training. Letters of recommendation will not be issued prior to completion of 80 hours of volunteer time.

Signature: _____

Date: _____

Please Note: Completion of this application dose not guarantee a volunteer position with the organization.

Exit Interview:

Deposit Returned: _____

Volunteer Signature