

# The MetroHealth System Volunteer Services

2500 MetroHealth Drive Cleveland, OH 44109

Phone: (216) 778-4471 Fax: (216) 778-1130

www.metrohealth.org

## Volunteer Application

### Personal Data

Name: \_\_\_\_\_  
(Last) (First) (Middle initial)

Address: \_\_\_\_\_  
(Number) (Street) (City) (State) (Zip code)

Phone: (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
(Home) (Cell)

Phone: (\_\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_  
(Other)

### Volunteer Interest

Please check the location(s) where you would like to volunteer:

- MetroHealth Medical Center** 2500 MetroHealth Drive Cleveland, OH 44109
- The Elisabeth Severance Prentiss Center for Skilled Nursing Care at MetroHealth**  
3525 Scranton Road SW, Cleveland, OH 44109
- The Senior Health & Wellness Center, MetroHealth Old Brooklyn Campus** 4229 Pearl Road,  
Cleveland, OH 44109
- Other** \_\_\_\_\_

Why are you interested in volunteering with The MetroHealth System? \_\_\_\_\_  
\_\_\_\_\_

When are you available to volunteer? \_\_\_\_\_

Please list your interests, skills, and hobbies: \_\_\_\_\_  
\_\_\_\_\_

Have you ever worked or volunteered for The MetroHealth System? Yes  No

If yes, indicate the facility, your position, and dates of service: \_\_\_\_\_  
\_\_\_\_\_

### References

Please list two persons we may contact for a personal reference. Do not list relatives.

1. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
(Number) (Street) (City) (State) (Zip code)

2. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
(Number) (Street) (City) (State) (Zip code)

*(Please see other side)*

## Experience

List your past three employers, beginning with your present or most recent job:

1. Employer: \_\_\_\_\_  
Position: \_\_\_\_\_ Dates: \_\_\_\_\_
2. Employer: \_\_\_\_\_  
Position: \_\_\_\_\_ Dates: \_\_\_\_\_
3. Employer: \_\_\_\_\_  
Position: \_\_\_\_\_ Dates: \_\_\_\_\_

Describe your present/past volunteer experience, including name of organization, type of assignment, and dates:

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If you are a student, what school do you attend? \_\_\_\_\_

## Miscellaneous

1. Have you ever been convicted of, or pled guilty or no contest to, a misdemeanor or felony? Yes  No   
(A "Yes" answer will not automatically disqualify you.)

2. Do you currently have pending any felony or misdemeanor charges against you? Yes  No

If you answered yes to question 1 or 2 above, please provide date of offense, charge, and city and state of court: \_\_\_\_\_

3. Person to be contacted in case of emergency:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

*I certify that all the information on this form is true and accurate. I understand that all application information will be verified and that false statements or omissions will be considered grounds for immediate dismissal, no matter when such information is discovered or reported to The MetroHealth System. I understand that if I volunteer, I must become familiar with and abide by all the policies of The MetroHealth System. I further understand that my volunteering is conditional upon satisfactory completion of reference and background checks.*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## For Volunteer Applicants Under the Age of 18

I give permission for my son/daughter, whose birth date is \_\_\_\_/\_\_\_\_/\_\_\_\_, to volunteer for **The MetroHealth System**. I verify that my son/daughter has not been convicted of any felonies or misdemeanors.

\_\_\_\_\_  
Signature of parent/guardian

\_\_\_\_\_  
Date