



Volunteer Application

(Please Print)

First Name _____ Last _____ Age _____ Date _____

Address: _____ City _____ State _____ Zip _____

SS# _____ Home/Cell Phone () _____ Work Phone () _____
(Required for background check)

E-Mail Address _____ Date of Birth _____ M/F _____ Marital _____

Emergency Contact: _____
Name Relationship Phone No.

Education _____ Hobbies _____ Skills _____

Foreign Languages Spoken _____ Referred By _____

Clubs, Organizations, Affiliated With _____

Previous Volunteer Experience _____

How did you find out about volunteering at Shriners Hospitals for Children - Tampa _____

Availability: Morning _____ Afternoon _____

Please circle: Mon. Tues. Wed. Thurs. Fri.

Area of work preferred: Patient Care Clerical Food Service Other: _____

Write a short paragraph about yourself including some of your main interests. Please include why you would like to be volunteer at Shriners Hospitals for Children - Tampa.

References: Please provide the names and **complete mailing addresses** of two people you have known, other than relatives, who could provide a recommendation. Recommendation forms will be mailed out and your application **cannot** be processed until the forms are completed and returned to the hospital.

Name Address, City, Zip Phone Number ()

Name Address, City, Zip Phone Number ()

(Do not write below this line)

Orientation: _____ Volunteer Number: _____ Assignment: _____

Starting Date: _____