



APPLICATION FOR
VOLUNTEER SERVICES
Tel: (617) 243-6048 Fax: (617) 243-5363
<http://www.nwh.org/>



NAME: _____
Last, First, MI Social Security # Database #
(Office use only)

Street Address (Local): _____

City: _____ State: _____ Zip: _____

Phone: _____ Email Address: _____
(Home) (Work or Cell)

In an emergency, notify: _____ Relationship: _____ Tel #: _____

PLEASE CHECK:

(*Needs parental consent form) 14-15* 16-17* 18 and over

EDUCATION:

High School: _____ Year of Graduation: _____

College: _____ Year of Graduation: _____

Area of Study: _____ Degree: _____

Graduate School: _____ Degree: _____

Other Schools or Special Training: _____

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:

Two persons other than relatives. If student, give advisor or faculty member and one other person.

Name: _____ Address: _____ Tel #: _____

Name: _____ Address: _____ Tel #: _____

Previous volunteer experience and/or community activities (where, when, what kind of work):

Are you doing this for course/community service? _____

If yes, how long and /or how many hours? _____

Contact person at school/community center/other: _____

Tel #: _____

Please list any special skills, interests and/or other hobbies: _____

Why do you want to volunteer at Newton-Wellesley? _____

What type of volunteer work are you interested in? _____

Days and times you are available? _____

I understand that my placement as a volunteer will be dependent upon demonstration of my ability to perform the duties required in the specific department to which I am assigned, and that I must comply with all Hospital policies, including, but not limited to, protection of patient privacy and confidentiality.

I affirm that all information provided on this application and accompanying material is complete and true. I understand that my acceptance into the volunteer program is contingent of satisfactory results of my health screening, criminal history check (CORI), and other information provided by me. I understand that the hospital reserves the right to terminate my service as a volunteer when, in the opinion of Volunteer Services, such action is in my best interest and/or that of the hospital.

By checking this box, I hereby authorize the use and reproduction by Newton-Wellesley 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 Newton-Wellesley Hospital.

Signature _____ Date: _____

***** FOR OFFICE USE ONLY *****

Area: _____

Schedule: Day: _____ Time: _____

Orientation Date: _____ Start Date: _____

Training: _____ Training Date: _____

M / F

A / M

D / E / W

Affiliation: _____

Limitations: _____

Interviewer's Comments:

Interviewer's Initials: _____ Date: _____

AUTHORIZATION FOR MINOR'S VOLUNTEER SERVICES

By my signature below, I give my permission for _____
to serve as a volunteer at Newton-Wellesley Hospital ("NWH").

If in the course of his/her volunteer services, _____ requires emergency
treatment, I consent to such treatment as deemed necessary by NWH.

Our family physician is: _____

He/she is located at: _____

And the telephone number is: _____

In the event I cannot be reached, I authorize NWH to contact the following person and to release such
information as necessary to obtain his/her assistance:

Name: _____ Relationship: _____

Address: _____

Telephone Number: _____

By checking this box, I give permission for my child to have a **criminal background check (CORI)**
conducted by NWH for volunteer placement.

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

Print Name of **Parent** or **Guardian**
(Please circle relationship)

Signature of Parent or Guardian

Date

Address

Telephone Number

Please direct any questions to NWH's Volunteer Services Department, at (617) 243-6048

➤ **OVER**

Consent to Provide Pre-placement Screening to a Minor

Name: _____ Employee ID: _____
Job Title: _____ Department: _____
Current Date: _____

I am the parent or legal guardian _____ and as such I authorize the Partners Occupational Health Services to provide medical care to my child for the purpose of screening my child for placement as either an employee or volunteer. I understand this care may include 1) drawing blood and testing it for immunity to measles, German measles, mumps, chickenpox, and Hepatitis B; 2)vaccinations against the infections listed and during flu season influenza vaccination; 3) a skin or blood test to check for tuberculosis infection; and/or 4) a chest x-ray if my child has had a positive skin test for tuberculosis in the past or during the pre-placement screening. I fully understand that if my child is being screened for employment (please note that this does not apply to students and volunteers), he/she is subject to the Pre-Hire Drug Testing Policy. My signature on this form serves as consent for my child to undergo pre-hire drug testing.

I understand that if my child requires vaccination I will be provided with a Vaccine Information Sheet by fax or email. I understand by law, all vaccines given by OHS or documented by OHS will be electronically sent to the MIIS (Massachusetts Immunization Information System) and that I have the right to limit who can see these records by completing the online "MIIS Objection Form" at www.mass.gov/dph/miis (also available at Occupational Health). By signing this form I acknowledge that I have read and understand this consent. I also understand that if I have any questions I can contact the Occupational Health Service at the number listed below so that my questions are fully answered prior to signing this consent.

_____	_____	_____
Print Your Name	Signature	Date
<i>I understand this consent is good for 1 year unless otherwise specified</i>		

Please provide contact information as we must forward you a Vaccine Information Sheet if your child requires any vaccines:

Email Address: _____
Fax: _____
Home Phone: _____
Cell Phone: _____

Occupational Health Services

MGH: (617) 726-2217 | BWH: (617) 732-6034 | BWFH: (617) 983-4628 | MCL: (617) 855-2438 | NWH: (617) 243-6181
NSMC Union: (781) 477-3211 | NSMC Salem: (978) 354-4466 | RCI: (508) 833-4178