Guam Memorial Hospital Authority
VOLUNTEER/VOLUNTEEN Application Form

Name:_____ Date:_____

Address:_____

Date of Birth:_____ Phone No._____ Cell or Pager: _____

Emergency Contact Information:

Name:_____ Relationship:_____

Address (Home):_____Phone No. _____

Previous Work Experience:

Occupation: _____Experience As a Volunteer: _____

Special Interests/Hobbies:_____

Area You Wish to Volunteer:_____

Circle day(s) and hours of your choice:

MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY

8:00 a.m. to 12:00 noon _____ 1:00 p.m. - 5:00 p.m. _____ Other: _____

Please answer the following questions:
1. Do you know that as a Volunteer you will not be paid for the services you provide?_____
2. Are you aware that you have to abide strictly to the rules and regulations of the hospital?_____
3. Is it your decision to willingly and faithfully do the work of a volunteer?_____

Parent's Signature:_____ Date: _____
(For 17 yrs. and below)

Volunteer/Volunteen's Signature:_____Date:_____

To be completed by Volunteer Coordinator:

P.E. Form to Employee Health:_____ Employee Health Clearance:_____
Drug Test: _____ Police/Court Clearance:_____
Time Sheet:_____ Complimentary Meal:_____
Orientation:_____ Badge No._____

Dept./Ward_____ **Approved to start:_____**
Authorized by:_____ **Volunteer Services Coord.:_____**
Dept. Supervisor