



Lakewood Ranch Medical Center

2019 VolunTeen Application

Please fill out the application completely. Omitted information will delay processing.

Date: _____

PERSONAL INFORMATION (PLEASE PRINT):

Last Name First Name MI How do you want your name to appear on badge?

Address Apt/Lot # City Use 9 digit Zip Code

Local Phone _____ E-Mail _____ Birthday _____ (Mo-day-yr)

Uniform Size: Available in men's and ladies sizes

Small ____ Medium ____ Large ____ X-Large ____ XX-Large ____ XXX-Large ____

IN CASE OF EMERGENCY PLEASE NOTIFY:

Name: _____ Relationship: _____

Address: _____ Home Phone: _____
Work Phone: _____

Physician: _____ Phone: _____

HOW DID YOU HEAR ABOUT OUR PROGRAM?

Friend ____ School ____ Internet ____ Other - please specify _____

VOLUNTEER AVAILABILITY: (please circle the days and times you are available to work)

MON	TUES	WED	THURS	FRI
8A-12P	8A-12P	8A-12P	8A-12P	8A-12P
12P-4P	12P-4P	12P-4P	12P-4P	12P-4P

COMMENTS: _____

Department Preference: _____

What do you envision yourself doing as a volunteer?

Have you volunteered in a health care setting before: Yes ____ No ____

If yes, describe the experience: _____

What about the health care setting is appealing to you?

If you need special assistance to perform your volunteer duties, please indicate those needs here:

Have you ever committed, been convicted of, pled guilty to, or pled nolo contendere to a felony or a misdemeanor?

No ____ Yes ____ If yes, please explain _____

NOTE: Conviction of a crime is not necessarily grounds for disqualification.

Contract of Confidentiality

As a Volunteer, I understand that I may come in contact with confidential information, both clinical and employee related, through, but not limited to, written records, documents, ledgers, internal correspondence and communications, computer programs and applications. I agree not to divulge or disclose to anyone other than those persons of Lakewood Ranch Medical Center and/or its affiliates who have "need to know", directly or indirectly, either during or after my services, any confidential information acquired during the course of my services. I understand and acknowledge that in the event I breach any provision of this agreement, Lakewood Ranch Medical Center, in addition to other legal remedies available to them, has the right to reprimand, suspend and/or terminate my volunteer service.

Volunteer Name: _____ Volunteer Signature: _____

Date: _____

The information provided in this application is true in all respects, without any willful omissions. I understand that if this application is false in any way I will be dismissed without notice regardless of when the false information is discovered.

As a VOLUNTEER I.....

- Agree to attend the volunteer orientation and train until I am competent to perform the required duties
- Agree to comply with all the rules and regulations of the hospital and the Volunteer Services Department
- Understand that I may be dismissed from my duties for willful wrongdoing or negligence and/or performing duties outside my service guidelines
- Agree to call my service area supervisor as soon as possible when I have scheduling changes

Volunteer Applicant signature

Date

Please return completed application forms along with two references and a copy of your immunization records to our Volunteer Services Department (by mailing or scanning and emailing) before 5pm on March 29th to:

Lakewood Ranch Medical Center
Attention: Volunteer Services
8330 Lakewood Ranch Medical Center
Lakewood Ranch, FL 34202

Or email to:

Tami.Caruso@lwrmc.com

Questions can be answered by calling: 941-782-2131