



Health Center

Volunteer Application

PLEASE TYPE OR PRINT CLEARLY

Mail Completed application to: Westside Family Health Center
1711 Ocean Park Blvd.
Santa Monica, CA 90405
Attn: Volunteer Coordinator

OR Fax completed application to: (310) 450-0873 Attn: Volunteer Coordinator
Please include a resume of your previous work experience, paid and volunteer

Name: _____
Last First Middle Initial

Address: _____
Street Address City State Zip Code

Home Phone: _____ Work Phone: _____

E-Mail Address: _____ Male _____ Female _____

SSN: _____ Birthdate: _____

IN CASE OF EMERGENCY:

Person to contact: _____
Name Relationship

Emergency Contact Phone Number: _____

Are you currently employed?

- Yes
- No Number of hours/week _____

Occupation _____

Can we contact you at work?

- Yes Best time & place for you to be reached? _____
- No

LENGTH OF COMMITMENT:

Dates: _____ / _____
Starting Date Ending Date

How many hours/week do you want to work? _____

AVAILABILITY:

What days of the week and times are you available?

	M	Tu	W	Th	F	Sa	Su
Times							
You are	_____	_____	_____	_____	_____	_____	_____
Available:	_____	_____	_____	_____	_____	_____	_____

EDUCATION:

	School Name	Major	Degree	Have you graduated?
High School	_____	_____	_____	_____
College	_____	_____	_____	_____
Post Grad	_____	_____	_____	_____
Trade School	_____	_____	_____	_____

LANGUAGES:

Spoken: _____
 Written: _____
 Read: _____

PROFESSIONAL TRAINING:

Do you hold a License/Certification in any Occupational Field?

- Yes If yes, what type? _____
- No Lic. # _____

OTHER INFORMATION:

- Have you ever volunteered at Westside Family Health Center (formerly known as Westside Women’s Health Center):
 - Yes
 - No
 If yes, in what capacity? _____

- Have you been convicted of a felony within the last 7 years? _____
 (Information will be kept confidential. Conviction will not necessarily disqualify an applicant)
 If yes, please explain: _____

 (You may attach a separate sheet, if necessary)

- Is this court-ordered community service?
 - Yes If yes, number of hours required: _____
 - No

REFERENCES:

Personal Reference

Name: _____

Phone #: _____

Describe how long you've known this person and your relationship with them: _____

Employment Reference

Supervisor's Name: _____

Phone #: _____

Company Name: _____

Describe your relationship with this employer, including duties and length of employment:

Volunteer Reference

Supervisor's Name: _____

Phone #: _____

Organization's Name: _____

Describe your volunteer assignments, length of time you served with this agency, and approximate hours/week: _____

- If you are under age 18, a parent/guardian's signature is required.

Parent/Guardian Signature

Date

I hereby certify that all information provided on this application is true and complete to the best of my knowledge. I further certify that I, the undersigned applicant, have personally completed this application. I authorize Westside Family Health Center to check the references I have listed and verify the information. I understand that falsification or significant omissions of any information may be considered justification for non-acceptance or dismissal, regardless of the time elapsed before recovery.

Applicant's Signature

Date

Thank you! We will contact you as soon as your application is processed.

For Office Use Only:

- | | |
|--|--|
| <input type="checkbox"/> Entered into DP: | <input type="checkbox"/> Orientation Scheduled (date): _____ |
| <input type="checkbox"/> Contacted: _____ | <input type="checkbox"/> Attended Orientation (date): _____ |
| _____ | <input type="checkbox"/> TB Test (result/date): _____ |
| _____ | <input type="checkbox"/> Physical Completed (date): _____ |
| <input type="checkbox"/> Start Date: _____ | |

Notes:

