UNIVERSITY OF CALIFORNIA, DAVIS, HEALTH SYSTEM
VOLUNTEER SERVICES

PLEASE PRINT

DATE _____

_____

Last Name First Name Initial

HOME ADDRESS _____
Street (include apartment number) City State Zip

E-MAIL ADDRESS _____

HOME TELEPHONE _____ WORK TELEPHONE _____

NOTIFY IN CASE OF EMERGENCY: Name _____

_____
Relation Home Telephone Work Telephone

Volunteer Area Preference: 1) _____ 2) _____ 3) _____

Time Available: Days _____ Hours _____

How did you hear about volunteering at UC Davis Health System?
☐ employee ☐ volunteer ☐ friend ☐ just called ☐ just knew ☐ relative ☐ high school ☐ college ☐ other _____

What skills can you offer while volunteering?

I would like to volunteer at UC Davis Health System because **(CHECK ONE ONLY)**:
☐ I want to help patients/hospital
☐ I am looking for job experience
☐ I am/will be a student/doing career exploration

Have you volunteered at UC Davis Medical Center before? _____ Date(s) _____

FOR STUDENTS: Name of School _____

_____

(Providing this data is voluntary. Noncompletion of this section will not preclude, enhance or detract from your opportunity to volunteer with the UC Davis Health System.)

DATE OF BIRTH _____ M/F _____

RACE/ETHNICITY (Please check one)
____ American Indian/Alaskan native
____ Black/African American (Not of hispanic origin)
____ Latin American/Latino (Including Cuban and Puerto Rican)
____ Mexican/Mexican American
____ Other Spanish/Spanish American
____ Other Asian (Including Far East, Korea, Southeast Asia or Pacific Islands, Samoa)
____ Chinese/Chinese American
____ East Indian/Pakistani
____ Filipino/Pilipino
____ Japanese/Japanese American
____ White/Caucasian (Including the Middle East)

I AM WILLING TO UPHOLD THE PURPOSE OF VOLUNTEER SERVICES which is to render service and support to the hospital, patients, and community served by the University of California, Davis, Health System, in accordance with the objectives established by that institution. IF ACCEPTED AS A HOSPITAL VOLUNTEER, I AGREE THAT I shall hold as absolutely confidential all information that I may obtain directly or indirectly concerning patients, doctors, or personnel, and not seek to obtain confidential information from a patient. MY SERVICES ARE DONATED to the hospital without payment or promise of future employment. FURTHER, I AGREE THAT I will sign in and out in the appropriate method for all hours volunteered.

UC DAVIS HEALTH SYSTEM provides medical treatment coverage for a volunteer who sustains an injury/illness in the scope of providing volunteer services to UC DAVIS HEALTH SYSTEM. Primary care treatment will be provided by Employee Health Services.

Volunteer Services Department reserves the right to release a Volunteer for:

- Failure to comply with hospital policies, rules and regulations.
- Unsatisfactory attitude, work or appearance.
- Continuous absences without prior notification
- Breach of confidentiality.

Have you been convicted of a felony or a misdemeanor which resulted in imprisonment? ☐ Yes ☐ No
Please explain circumstances, places and dates.

_____
Signature

Please list employment, school or volunteer activities for the past five years.

OFFICE USE ONLY

Placement

Orientation Date: _____

Department Name _____ Cost Center/Code _____ Pay Code _____

S M T W Th F Sa / Time _____ First working day _____

Individual placement: Y N Send letter: Y N

2nd Placement

Department Name _____ Cost Center/Code _____ Pay Code _____

S M T W Th F Sa / Time _____ First working day _____

Waiting List #1

Department Name _____

Day preferred, if any: S M T W Th F Sa

Time preferred, if any _____

Waiting List #2

Department Name _____

Day preferred, if any: S M T W Th F Sa

Time preferred, if any _____