LAKE TAYLOR
TRANSITIONAL CARE HOSPITAL

VOLUNTEER APPLICATION

(Applicant's Name - Last, First, Middle)	Birthday	Soc. Sec. No:
(Home Address) (City) (Zip)		Home Ph. # Office #:

Education:

Experience: (Volunteer & Paid Work)

Special Skills:

Special Interests & Hobbies:

My address and phone number may be distributed to other volunteers [ ] Yes [ ] No

ENTER DAYS AND HOURS AVAILABLE

	Morning	Afternoon	Evening
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

Physician Name: _____

Address: _____

Phone: _____

P.P.D. results within the last year:

Date: _____ Results: _____

Name & Address of Person to Contact in Case of Injury or Illness While on Duty Phone #

List Two Personal References (Give Name, Address, Zip) Phone #

Phone #

How Did You Learn of Our Volunteer Program?

I, the undersigned applicant, certify that all statements made in this application are true, to the best of my knowledge and belief, and I hereby give permission for the verification of same, as deemed necessary by the Department Head.

_____ _____
Applicant's Signature Date

1309 Kempsville Road, Norfolk, VA 23502 (757) 461-5001