



Harris County Hospital District

Date: _____

Department of Volunteer and Guest Services

Ben Taub General Hospital - Lyndon B. Johnson General Hospital
Quentin Mease Community Hospital – Community Health Centers
Ben Taub Volunteer Office Tel: 713-873-2203 Fax: 713-873-4993
LBJ Volunteer Office Tel: 713-566-5156 Fax: 713-566-5158

(This application will be kept confidential)

Volunteer Application

Personal Contact Information

Last Name: _____ First: _____ Middle: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Social Security No: _____

Driver's License or ID#: _____ Date of Birth: _____ Sex: Male Female

Race\Ethnicity: _____ Profession: _____

Current Employer or School attending: _____

Emergency Contact Information

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

General Information

Hobbies, interests, or skills: _____

Languages (fluent):	English	<input type="checkbox"/> Speak	<input type="checkbox"/> Read	<input type="checkbox"/> Write
	Spanish	<input type="checkbox"/> Speak	<input type="checkbox"/> Read	<input type="checkbox"/> Write
	Vietnamese	<input type="checkbox"/> Speak	<input type="checkbox"/> Read	<input type="checkbox"/> Write
	Other: _____	<input type="checkbox"/> Speak	<input type="checkbox"/> Read	<input type="checkbox"/> Write

How did you learn about our program? _____

Why are you interested in Volunteering for the Harris County Hospital District? _____

Any previous Volunteer experience? If so, where? _____

What is your preferred location of assignment? (please circle)

Acres Homes Health Center

E. A. "Squatty" Lyons Center

Quentin Mease Hospital

Aldine Health Center

Gulfgate Health Center

MLK Health Center

Baytown Health Center

Settegast Health Center

Thomas Street Health Ctr.

Ben Taub General Hospital

LBJ General Hospital

Strawberry Health Center

Casa de Amigos Health Ctr.

Northwest Health Center

Dental Center

People's Health Center

What days and times are you available to volunteer?

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning							
Afternoon							
Evening							

Please be as specific as possible. We ask for a minimum commitment of three hours per week for three months.

Medical Information

The Harris County Hospital District Volunteer Program is available to all, without regard to race, color, national origin, disability, gender, political affiliation or religion.

Are you currently being treated for any medical conditions that Volunteer Services should know about? Yes No

If so, please list them: _____

Are you currently taking any medications that Volunteer Services should know about? Yes No

If so, please list them: _____

FOR OFFICE USE ONLY:

Criminal Background Check: _____

Volunteer Position Schedule:

Invite to Orientation Sent: _____

Day: _____

Personal Interview Scheduled: _____

Time: _____

TB test scheduled: _____

Assignment: _____

Badge Appointment scheduled: _____

Training: _____

Entered into Database System: _____

Volunteer Statement and Background Check Authorization:

I, _____, certify that all of the information provided in this volunteer application is true and correct to the best of my knowledge. I authorize HCHD to conduct any and all inquiries necessary to determine my acceptability as a volunteer, including a thorough background check. I understand that this background check may include verification of personal and/or employment references, military information, or police record inquiries. The following will help to facilitate this process:

Have you ever been convicted of or have plead guilty, no contest, (nolo contendere), or received deferred adjudication for any criminal offense, including both misdemeanors and felonies? Answering "yes" will NOT automatically bar you from volunteering. If yes, please indicate the requested information below. If you need additional space, please continue on a separate sheet of paper.

Date:	Charge:	City / State:	Disposition:

Signature: X _____ Date: _____

APPLICATION CANNOT BE PROCESSED WITHOUT SIGNATURE

HCHD Volunteer Agreement:

I have reviewed and understand all of the information provided by the Harris County Hospital District regarding the Volunteer Program and my responsibilities as a volunteer.

I understand that all Harris County Hospital District medical records and patient records shall be treated as confidential information. I further understand that as a Harris County Hospital District volunteer I am bound by Federal, State and Local laws and regulations regarding medical records and governmental records.

I shall hold the Harris County Hospital District and any employee or agent thereof harmless against any injuries sustained by me, or any other persons, arising from my actions or the actions of others.

Printed Name: _____ Date: _____

Signature: X _____

HCHD Rep Signature: _____ Date: _____

In addition to filling out this application you must:

- Pass a criminal background check.
- Receive an invitation to attend the General Volunteer Orientation.
- Schedule a brief interview with a Volunteer Coordinator.
- Submit proof of a negative TB skin test within the last year.
- Be issued a security badge.

PLEASE BE SURE YOU HAVE COMPLETED THE APPLICATION IN ITS ENTIRETY.

***All incomplete applications that have not had any activity for three months will be discarded.**