

# Volunteer Services Application

We consider applications for all positions without regard to race, color, religion, creed, sex, national origin, age, ancestry, disability, or political affiliation.

Name: \_\_\_\_\_  
Last First Middle Initial

Address: \_\_\_\_\_  
Street City State Zip

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Current Employment (if any): \_\_\_\_\_  
Company Name Supervisor

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Month Day Year

In case of emergency/illness, notify: \_\_\_\_\_  
Name Phone Relationship

Have you ever been convicted of a crime?  Yes  No If yes, please explain: \_\_\_\_\_

Previous volunteer experience (include organization name, address, and dates volunteered): \_\_\_\_\_

How did you become aware of the Volunteer Program at Children's Care? \_\_\_\_\_

Days Preferred (check):  Mon  Tues  Wed  Thurs  Fri  Sat  Sun

Hours Preferred: \_\_\_\_\_ Mornings: \_\_\_\_\_ Afternoons: \_\_\_\_\_ Evenings: \_\_\_\_\_

Areas of special interest and hobbies: \_\_\_\_\_

Special training/skills applicable to volunteer work at Children's Care: \_\_\_\_\_



**CHILDREN'S CARE**

2501 W. 26th St., Sioux Falls, SD 57105-2498 (605) 782-2300  
www.cchs.org

## Applicant's Statement

- I agree to respect the confidential nature of any medical or personal information that I may learn regarding students/patients at Children's Care Hospital & School. Failure, on my part, to comply with this request may result in my dismissal as a volunteer.
- I certify that all statements made by me on this application are true and complete to the best of my knowledge and that I have withheld nothing that would, if disclosed, affect this application unfavorably.
- I understand that smoking and the use of related tobacco products by all persons will be prohibited on Children's Care Hospital & School and affiliate premises including the company facilities, grounds, and vehicles.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*If Under the Age of 18:*

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

### References:

Due to our caring concern for the children at Children's Care Hospital & School, we require each volunteer to submit two character references (other than family members). Information received will be kept confidential.

1. Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

2. Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_



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