



The Cleveland Clinic is an Equal Opportunity Employer, and as such prohibits discrimination due to race, religion, gender, age, national origin, and physical or mental handicaps. Completion of an application and attendance at orientation does not guarantee placement. Decisions concerning assignments are contingent upon a successful interview, security clearance and TB testing.

Volunteer Application: Please print and mail or fax to 702.701.7954. All signature lines need a signature, not printed or typed.

Name _____ Date of Application _____
 First Middle Initial Last

Current Mailing Address _____ City/State/Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email address _____ Preferred Contact _____

Uniform Shirt Size: Small Medium Large X-large XX-Large XXX-Large (Please circle one)

Availability

Date available to begin _____ Total hours per week _____

HOURS	MON	TUES	WED	THURS	FRI	SAT	SUN
MORNING							
AFTERNOON							
EVENING							

How long do you plan to volunteer at CCLRCBH _____ Months _____ Years

Limitations

Are there any reasonable accommodations we should consider? Yes No

If yes, describe: _____

Emergency Contact Information

Name _____ Relationship _____

Address _____ City/State/Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Education: List academic vocational or professional education and schools attended.

Do you have any special skills, interests, hobbies, or musical talent that you think might benefit our patients and caregivers?

Are you bilingual? Language _____ Speak _____ Read _____ Write _____

Language _____ Speak _____ Read _____ Write _____

If called upon would you be willing to assist staff as an interpreter if needed? Yes No

Employment and/or Volunteer Experience

Are you currently employed? Yes No if yes, employer name: _____

Please list any verified volunteer service you have done in the past

Organization	Organization
Address	Address
Dates: from to	Dates: from to
Assignment	Assignment

Person(s) employed with CC or KMA with whom you are related:

Name _____ Dept _____ Relationship _____

(Volunteers will not be assigned to same area as related employee.)

Areas of Interest

Indicate all areas where you have a volunteer interest.

- | | |
|-------------------------------------------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> Keep Memory Alive Fundraising Events and Activities | <input type="checkbox"/> Community Events |
| <input type="checkbox"/> Volunteer Callers (patient appointment reminders) | <input type="checkbox"/> Docent (tours of building) |
| <input type="checkbox"/> Caregiver Support Activities (Outreach) | <input type="checkbox"/> Resource Library (caregiver library) |
| <input type="checkbox"/> Administrative Office Assistance | <input type="checkbox"/> PT/OT (assist patients & caregivers) |
| <input type="checkbox"/> Lobby (facilitate patient and guest) | |
| <input type="checkbox"/> Clinic Admin Assist (phones, faxing, scanning, etc.) | |



VOLUNTEER SERVICES PROFESSIONAL REFERENCE FORM

Name of Reference _____

Address _____
Street City State Zip

Reference e-mail address _____ Phone _____

Applicant _____

The above applicant has applied for a volunteer position with Cleveland Clinic Lou Ruvo Center for Brain Health. We would appreciate your cooperation in checking the appropriate spaces below as they pertain to your knowledge of this applicant. Return this form at your earliest convenience, as the applicant's file is not complete without verified references. Thank you for your anticipated cooperation.

Karen Mariano, Admin Program Coordinator I
Volunteer Services
mariank@ccf.org or 702.331.7046
Fax: 702.701.7954

Number of years you have known applicant _____

Relationship to applicant: (friend, relative, employer, etc.) _____

Please indicate how you rate the applicant with regards to the following four character qualities:

	POOR	FAIR	AVERAGE	ABOVE AVERAGE	OUTSTANDING
Reliability					
Confidentiality					
Commitment					
Integrity					
Creativity					

Additional Comments

Cleveland Clinic Lou Ruvo Center for Brain Health has my permission to contact directly references I have listed or any other sources concerning my prior volunteer, professional or personal history, and I release all parties from any possible damages from disclosing such information with or without prior notice from me.

Potential Volunteer Signature _____ Date _____

Reference Signature _____ Date _____



VOLUNTEER SERVICES PERSONAL REFERENCE FORM

Name of Reference _____

Address _____
Street City State Zip

Reference e-mail address _____ Phone _____

Applicant _____

The above applicant has applied for a volunteer position with Keep Memory Alive on behalf of the Cleveland Clinic. We would appreciate your cooperation in checking the appropriate spaces below as they pertain to your knowledge of this applicant. Return this form at your earliest convenience, as the applicant's file is not complete without verified references. Thank you for your anticipated cooperation.

Karen Mariano, Admin Program Coordinator I
Volunteer Services
mariank@ccf.org or 702.331.7046
Fax: 702.701.7954

Number of years you have known applicant _____

Relationship to applicant: (friend, relative, employer, etc.) _____

Please indicate how you rate the applicant with regards to the following four character qualities:

	POOR	FAIR	AVERAGE	ABOVE AVERAGE	OUTSTANDING
Reliability					
Confidentiality					
Commitment					
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Creativity					

Additional Comments

Cleveland Clinic has my permission to contact directly references I have listed or any other sources concerning my prior volunteer, professional or personal history, and I release all parties from any possible damages from disclosing such information with or without prior notice from me.

Potential Volunteer Signature _____ Date _____

Reference Signature _____ Date _____