



Los Robles Hospital Volunteers, Inc.
 215 W Janss Road, Thousand Oaks, CA 91360
 805 370-4685

Adult Volunteer Application
 PLEASE PRINT CLEARLY

M F

LAST NAME FIRST Nickname (as you would like it on your badge)

STREET ADDRESS CITY ZIP

HOME PHONE (include area code) CELL PHONE (include area code) T-SHIRT SIZE

E-MAIL ADDRESS PREFERRED PRONOUNS (optional)

ARE YOU A MEMBER OF CSVP? _____ WOULD YOU LIKE TO BECOME A MEMBER? _____

CURRENT EMPLOYMENT/SCHOOL

ADDRESS

POSITION

HAVE YOU EVER BEEN EMPLOYED/VOLUNTEERED AT LOS ROBLES HOSPITAL AND MEDICAL CENTER? _____

PLEASE LIST TWO REFERENCES OTHER THAN FAMILY:

NAME PHONE EMAIL

NAME PHONE EMAIL

List participation in other community organizations:

Are you able to serve four hours per week on a regular basis for at least 10 to 12 months? _____

Please check the days of the week you are available: Sunday Monday Tuesday Wednesday Thursday Friday Saturday

Do you have any physical condition or disability which may limit your ability to perform any Volunteer duties? Please explain

I understand that my volunteer status is pending satisfactory results of a TB skin test, background investigation, satisfactory proof of identity, as well as training, the needs of the hospital and provisional periods. Hereby I authorize Los Robles Hospital & Medical Center to make any investigation of my background deemed necessary.

I agree to conform to the rules, regulations and policies of Los Robles Hospital & Medical Center and Los Robles Hospital Volunteers, Inc.

I certify that all answers or statements I have made on this application or other supplementary materials are true and correct without omissions. I acknowledge that any false statements or misrepresentations on this application or other supplemental material, not abiding by rules, regulations and policies, will be cause for dismissal from the Los Robles Hospital Volunteers, Inc., program. I also understand that I am required to have a yearly flu shot and maintain current vaccinations as mandated by Los Robles Hospital and Medical Center.

SIGNATURE OF APPLICANT DATE