



Volunteer Application

Legal Name: _____ Yes, I am at least 16 years old

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ home cell work Email: _____

Employer/School: _____ Student: Yes No

Emergency Contact: _____ Relationship to you: _____

Phone(s): 1. _____ home cell work 2. _____ home cell work

- **Minimum requirement: One 2-hr shift per week for a minimum of 5 months**
- **No summer only, evenings (except Wednesday) or weekends are available**

Check days available: Monday Tuesday Wednesday Thursday Friday
(may select more than one)

Shifts(s) Available (8:00 a.m. to 4:30 p.m.): Morning Afternoon
 Evening (Wednesday only for Recreation Therapy)

AREA(S) OF INTEREST:

- Recreation Therapy (2:30-5 (M-F); 10:30-12 (Fri only)) Driving (on-call)
 Tutor (English, Math, Writing, K-12, ages 4-18) Medical Records (filing charts/documents)
 Clerical

Computer Skills: Word Excel Other: _____

***For Physical Therapy (only mornings available), please contact the department directly at (808) 951-3626.**

Describe any education, work or volunteer experiences related to the volunteer area(s) of interest:

Why do you want to volunteer at Shriners Hospital? _____

Please list two character references: (no family members, boyfriend/girlfriend, or minors):

Name: _____ Email: _____

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

Phone: _____ Relationship to you _____

Name: _____ Email: _____

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

Phone: _____ Relationship to you _____

1. Have you ever been convicted of a crime that is related to the responsibilities of the volunteer position for which you are applying? Yes No If yes, please explain: _____

2. Do you have any medical condition(s) that would prevent/limit you from completely fulfilling the responsibilities of your volunteer position? Yes No If yes, please explain: _____

I certify that all information contained on this application is true and authorize Shriners Hospitals for Children-Honolulu to secure information about my experience from references that I have provided.

I understand the minimum requirement to volunteer is at least one (1) 2-hour shift per week for a minimum of 5 months.

Applicant's Signature: _____ Date: _____

Parental Consent: All applicants less than 18 years of age at the time of application must have the following section completed by a parent or legal guardian.

- I hereby give permission for my son/daughter to volunteer at Shriners Hospitals for Children-Honolulu. I understand that my son/daughter will be undertaking responsibilities at the hospital as a volunteer only and hereby approve of the hours he/she chooses to volunteer.

Parent/Guardian's Name (print): _____

Signature: _____ Date: _____

Any questions, please call the Volunteer Program at 951-3686 (Derek Ito or Wendy Miyaji)

**Applications may be returned by mail to: Shriners Hospitals for Children,
1310 Punahou Street, Honolulu, HI 96826, Attn: Volunteer Program
OR by email to: apply.hon@shrinenet.org**