

Dear Friend:

Thank you for your interest in Hawaii Pacific Health's Volunteer Programs at Kapi`olani Medical Center for Women & Children, Pali Momi Medical Center, and Straub Clinic & Hospital.

We are pleased to offer you the enclosed information and application for our program. Please review the information; and if some areas in the program attract your attention, please complete the application and return it to us. All applications are processed through the main volunteer office located at Kapi`olani Medical Center for Women & Children. Please address envelope to:

Kapi`olani Medical Center
Volunteer Office
1319 Punahou Street
Honolulu, HI 96826.

After reviewing your application, we will inform you if there are openings in the areas in which you are interested or days that you are available. The entire process usually takes three to four weeks.

Our non-profit medical system is committed to improving the health and well-being of the people of Hawaii and the Pacific Region through a family of hospitals, clinics, outpatient centers, and hundreds of physicians and clinicians throughout Hawaii. Our volunteers are vital to the success of these programs and services.

Thank you for your interest in becoming an important part of our dedicated health care team. We look forward to hearing from you.

Sincerely,

Lisa

Lisa L. Chung
Director of Volunteer Services

HAWAI' PACIFIC HEALTH

Kapi'olani • Pali Momi • Straub • Wilcox

VOLUNTEER SERVICES • 1319 Punahou Street • Honolulu, Hawaii 96826 • Phone: (808) 983-8281 • Fax: (808) 983-6754

ADULT VOLUNTEER APPLICATION

(Select the Medical Center you are applying for)

PALI MOMI

98-1079 Moanalua Road, Aiea

STRAUB CLINIC & HOSPITAL

888 S. King Street, Honolulu

WOMEN & CHILDREN

1319 Punahou Street, Honolulu

GENERAL INFORMATION

Name: _____ Birthday: _____
Last First MI Month/Day

Address: _____ City: _____ Zip: _____

Phone (Home): _____ (Work/Cell) _____

E-mail Address: _____

Emergency Contact Person: _____

Relation: _____ Phone:(H) _____ (B) _____

Physician Name: _____ Phone: _____

Have you ever been convicted of a felony? Yes ___ No ___ If yes, explain when, where, type of offences and disposition of case. (A conviction will not necessarily disqualify application from the position applied for.)

AVAILABILITY

What are the days/times you are available to volunteer? Please check below:
(Minimum 4 hrs. a week; a consecutive 4-hour shift or two 2-hour shifts.)

8/8:30a.m. - Noon/12:30p.m.

Mon Tues Wed Thu Fri Sat Sun

Noon/12:30p.m. - 4/4:30p.m.

Mon Tues Wed Thu Fri Sat Sun

4:30/5:00p.m. - 8:30/9:00p.m.

Mon Tues Wed Thu Fri Sat Sun

Can you commit to a regular schedule? Yes No

DO NOT WRITE BELOW - FOR VOLUNTEER OFFICE USE ONLY

Date Rec'd: _____ Interview Date: _____ Orient.Date: _____

Assign: _____ Day(s) _____ Time: _____ Start Date: _____

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HEALTH RECORDS: TB: (1) _____ (2) _____ or +PPD _____ mm _____ & X-Ray _____

MMR _____ Varicella _____ Flu _____ For HT/RT only: Hep B Titre _____ or Hep B Series; #1 _____ #2 _____ #3 _____

BG Ck submitted: _____ BG Ck Received: _____ N.O.L: _____

Comments:

TYPES OF ASSIGNMENTS YOU ENJOY

- Patient Escort
- Book Cart
- Reading to Patients
- Arts & Crafts with Patients (Kapi`olani Medical Center for Women & Children only)
- Running Errands
- Gift Shop
- Patient Greeter/Visitor Assistant/Hospitality

OTHER INFORMATION

Current Employer: _____ Position/Title: _____

School: _____ Major: _____

Work experience (paid or volunteer): _____

Career/special interests, hobbies, skills: _____

List special training or noteworthy achievements: _____

Why do you want to volunteer? _____

Future Objectives _____

REFERENCES

Name three individuals (not related) who have knowledge of your qualifications and whom we have permission to contact immediately, preferably individuals under whom you have worked.

Name	Title/Occupation	Where Employed	Phone Number

I certify that all statements made in the application are true. I understand that if selected for a volunteer position, falsified statements on this application or failure to furnish all requested information shall be considered sufficient cause for my dismissal from the volunteer program. I agree to a criminal background and reference check. I agree to abide by the policies and regulations of Hawai'i Pacific Health and its Volunteer Program.

Signature: _____ **Date:** _____

Please sign and submit this application to:
Kapi'olani Medical Center
Volunteer Services Department
1319 Punahou Street
Honolulu, Hawaii 96826

The application process must be completed within three months of the date of receipt. If you have been notified of incomplete information and have not contacted the volunteer office, your application will be removed.