Physical Therapy Department
Occupational Therapy Department
VOLUNTEER APPLICATION

Date: _____

Last Name: _____ First Name_____

Date of Birth: _____ Age: _____ Gender: M ☐ F ☐

Street 1: _____

Street 2: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Email: _____

Please check off all that apply:

☐ Employed (Full or part time) ☐ Self-employed/freelance ☐ Unemployed ☐ Retired
☐ Under 16 years of age ☐ Student (Full or part time) ☐ 16 or 17 years of age

Are you authorized to work or study legally in the United States? ☐ Yes ☐ No

Highest Level of Education Completed:

☐ Associates Degree ☐ Bachelors Degree ☐ Doctoral Degree ☐ GED ☐ High School
☐ Masters Degree ☐ Military ☐ Some College ☐ Vocational/Trade School ☐ Other*
**If other, please specify*: _____

Summer Only Applicant: Yes ☐ No ☐

Current School: _____

Expected degree_____ Expected Graduation date_____

Employer: _____

Employer Address: _____
_____
_____

Availability

Can you make a 120 hour commitment to volunteer at NYU Langone Medical Center **at the same day and time every week?**

☐ Yes, I can make a weekly commitment for:

☐ 6 Months ☐ 12 months

No, I cannot make a weekly commitment for 6 or 12 months but

I can commit to: _____ months.

Please circle the days and write in the times for each day you are available to volunteer, the same day & time, each week.

Example:	*Wednesday*	*Thursday*	*Friday*	*Saturday*	*Sunday*
	10 am – 2 pm	*6 –10 pm*	_____	*8 am – 10 pm*	_____

Days:	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours:	_____	_____	_____	_____	_____	_____	_____

Language(s) spoken and/or written other than English

_____

Emergency contact information:

Name_____

Relationship _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Email: _____

Reference

Please provide a reference letter from the contact person below (CANNOT BE A RELATIVE)

Name: _____

Address: _____

_____

Relationship _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Email: _____

Volunteer Experience

Please list your most ***recent*** volunteer experience:

Name of organization _____

Volunteer Dates: From _____ to _____

Name of supervisor and phone # _____

Please describe volunteer duties

_____

_____

Have you ever volunteered at NYU Langone Medical Center before? ☐ No ☐ Yes

If Yes, when? _____

Questions:

PLEASE NOTE: YOUR APPLICATION WILL NOT BE CONSIDERED UNLESS ALL QUESTIONS ARE COMPLETED.

Why would you like to volunteer at NYU Langone Medical Center's Physical Therapy/Occupational Therapy Department? What do you hope to gain from this experience?

_____

_____

_____

_____

List and explain any additional volunteer experience you have had in a hospital, medical center or doctor's office related to Physical Therapy/Occupational Therapy

_____

_____

_____

_____

Have you ever been convicted of a crime? If so, please specify nature, date of conviction and penalty.

_____

_____

_____

_____

Are you required to volunteer? (i.e. court mandate, school requirements, college coursework, etc.) Please document specific information for this requirement.

_____

_____

_____

_____

Certification of Application

I understand and agree that submitting this application form does not automatically register me as a volunteer at NYU Langone Medical Center. I am aware there are certain qualifications I must meet including orientation, medical clearance, background check and a 120 hour commitment. By submitting this form, I attest that the information I have provided on the form is true, accurate and NOT provided by a third party.

Name _____ Date_____