Memorial Healthcare System

Dear Prospective Volunteer:

Thank you for your interest in volunteering at Joe DiMaggio Children's Hospital. We are pleased that you have chosen our hospital.

All volunteers are required to give a minimum of a four-hour shift per week within a six-month commitment. In addition, volunteers will require the following:

- Government-issued ID
- Letter of recommendation (for teens 15yrs. to 17yrs. old)
- Background check (provided by Memorial Healthcare System)
- Tuberculosis Screening (provided by Memorial Healthcare System)
- Flu vaccine required during flu season. (October 1st – March 31st)
- Complimentary Uniform
- Attend a new volunteer orientation.

Please complete and click the submit button at the bottom of the application. In addition, send your letter of recommendation and government-issued ID to JDCHVolunteer@mhs.net.

Please note we do not accept Court-Ordered Community Service.

Applicants will be accepted based on an interview and the needs of the hospital. Please contact the Volunteer Services Office at 954-265-0193. if you have any questions prior to completing the Volunteer Application.

Again, thank you for your interest in joining our Memorial Healthcare System Team.

Sincerely,

Volunteer Services Department
Joe DiMaggio Children's Hospital
1005 Joe DiMaggio Dr.
Hollywood, FL 33021

Joe DiMaggio Children's Hospital

Joe DiMaggio Children's Hospital

Volunteer Application

Name Last:*		First:*		M.I.:	
Address:*					
City:*		State:*		Zip:*	
Phone Number:*					
Are you between the age of 15yrs. -18yrs.?* ☐ Yes ☐ No					
Applicants E-mail address:*					
Emergency Contact Name:*		Relationship:*		Phone Number:*	
Previous/Current Occupation:					
School currently attending:					
Special abilities/skills:					
Do you speak/write an additional language? If yes, please indicate the language(s):					
Please list any prior volunteer experience you have:					
Please list any duties you're unable to perform?					
How did you hear about our volunteer program: Do you have any friends or family affiliated with MHS?					
What are you hoping to gain from your volunteer experience?					

***PLEASE CHECK THE TIMES AND DAYS YOU ARE AVAILABLE TO VOLUNTEER**

TIME	MON	TUE	WED	THU	FRI	SAT	SUN
9AM – 1PM	☐	☐	☐	☐	☐	☐	☐
1PM – 5PM	☐	☐	☐	☐	☐	☐	☐
4PM – 8PM	☐	☐	☐	☐	☐	☐	☐

PLEASE SELECT THE AREA YOU WOULD LIKE TO VOLUNTEER IN
(Please note that each hospital site has different areas of opportunity)

Pediatric Emergency Room:_____ Child Life Playrooms:_____ Child Life Zone:_____ NICU:_____
Surgical Services:_____ Nurses Station:_____ Respiratory:_____ Wellington:_____
Food Pantry:_____ Imaging:_____ Family Resources Center:_____ Greeter/Lobby:_____
Classroom:_____

Signature:* _____ Print Name:* _____

Parent / Legal Guardian Signature: _____
(Under 18 years of age)

Joe DiMaggio Children's Hospital®

Please note we do not provide court-ordered community service hours.

Agreement to Conduct a Background Check

☐ *By clicking the 'checked' box, I understand and agree that as a part of the application process to be considered for a volunteer position at Joe DiMaggio Children's Hospital, Memorial Healthcare System will conduct a criminal background check. I agree that if I am accepted to the volunteer program, and if any information I have provided is found to be false or misleading in any way, I may be subject to dismissal from the program.

Signature:* _____ **Date:*** _____

Parent Signature: **Date:**

(Required if under 18 years of age)

Note: All (*) fields are required

SUBMIT