VOLUNTEER APPLICATION FORM

Contact Information

Please list your contact information in this section.

First name: _____

Last name: _____

Street: _____

City: _____

State: _____ Zip: _____

Home phone: _____

Work phone: _____

Cell phone: _____

Email address: _____

Demographic Information

Please provide the following demographic information. It is used only to help us get a better idea of the demographic make-up of our volunteers.

Date of birth: _____/_____/_____
month date year

Age range: ❑18 to 64 ❑65 to 79 ❑80 and over ❑under 18

Gender: ❑Male ❑Female

Reason for Volunteering

Please list here your reason for volunteering and what you hope to get out of the experience.

Please also provide your time availability. _____

_____

Emergency Contact

Please enter your emergency contact information that you would allow the hospital to contact on your behalf.

First name: _____

Last name: _____

Home phone: _____

Work phone: _____

Cell phone: _____

Relationship: _____

Occupation

Please list here where you go to school or work.

Are you a student?: ❑Yes ❑No

Name of school: _____

Are you currently employed?: ❑Yes ❑No

Name of employer? _____

Language Proficiency

Please list here all the Asian languages you speak.

_____

Questions or Comments

Please use this section for any questions or additional information.

_____

_____

Agreement Statement

I understand that various pictures may be taken by ABHOP during the year. I give my permission for my picture(s) to be used in the ABHOP website, publications and/or demonstrations at the discretion of ABHOP. I agree to release, indemnify, defend and hold harmless ABHOP, Methodist Richardson Medical Center, and/or staff or any of its affiliates from and against any and all loss and damages which might result to you in connection with the pictures.

If accepted to volunteer, I understand and will not hold liable Asian Breast Health Outreach Project, Methodist Richardson Medical Center, and/or staff or any of its affiliates for any injuries that I may sustain during the event. I understand and will abide by the confidentiality and privacy rules of patient and/or individual information shared in conjunction to any work of and with ABHOP. I certify the accuracy of all information provided in this application. By signing below, I agree to all terms and conditions stated therein.

_____

Your Signature

_____

Date

Please fax or mail back this application form to:
Methodist Richardson Medical Center
Centers for Women's Health/ABHOP
403 W Campbell Rd, Ste 205
Richardson, TX 75080
Fax: (972) 498-8634

For questions, please call (972) 498-8603. We will call you upon receipt of your application.
Thank you for your interest.