



NON-STUDENT APPLICATION

Ronald Reagan UCLA
757 Westwood Plaza, Suite B791
Los Angeles, CA 90095
(310) 267-8180

Santa Monica UCLA
1250 16th Street
Santa Monica, CA 90404
(424) 259-8176

UCLA Health is committed to a policy of equal opportunity for all applicants for volunteer positions and for all volunteers. UCLA Health does not discriminate against any applicant or volunteer based on, and considers each applicant and volunteer without regard to sex, race, color, national origin, ancestry, citizenship, pregnancy, age, marital status, medical condition, physical disability, mental disability, or sexual orientation.

Date: ____/____/____	Student ID# _____ (Applies to UCLA students only)
(Circle title) Dr. Mr. Mrs. Miss	
Name:	
Last:	First:
Middle:	
Gender (circle one) M / F	
Permanent address:	
Street Address:	Apt. #:
City:	State:
Zip Code:	
Phone # (with area code): () -	E-mail address: _____ @ _____
Cell phone# () -	Birth Date: Month: _____ Day: _____ Year: _____
Present employer: _____	
Phone #: ()	
Emergency contact:	Emergency phone #: () -
Have you ever been convicted of a felony or misdemeanor (including a conviction for which the record has been sealed, expunged, or judicially dismissed)?	
Yes _____ No _____	
If yes, please explain. A felony or misdemeanor conviction will not necessarily disqualify an applicant from being offered a volunteer position.	
Have you ever been arrested for a drug or sex offense? (If yes, please explain) Yes _____ No _____	
How did you hear about our program?	

Please state your reasons for volunteering along with any of your special skills and qualities that would benefit our volunteer program. (Please do not exceed the allotted space.)

Are you legally eligible to work in the United States?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Will you now, or in the future, require visa sponsorship for volunteering at UCLA Health?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please give the type of visa and date of expiration.	Visa type:	Expiration Date:
Name of local reference (not a relative):		
Phone #:	Relationship:	
Are you currently attending school? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of school:	
What are your reasons for volunteering?		
Previous volunteer experience:		
Foreign languages:		

VOLUNTEER AGREEMENT AND CERTIFICATION OF INFORMATION

Believing that UCLA Health has need of my services as a volunteer, I agree:

1. To hold as absolutely confidential all information that I may obtain directly or indirectly concerning patients, families, physicians, or personnel. I agree that I will not seek confidential information in regard to a patient.
2. That I am applying for an unpaid, volunteer position and not paid employment. I understand and agree that neither this volunteer application nor the acceptance or performance of a volunteer position constitutes an employment relationship or a contract of employment. I further understand and agree that neither this volunteer application nor the acceptance or performance of a volunteer position constitutes a guarantee or promise of future employment.
3. That if I accept a volunteer position, I will have a duty to be familiar with UCLA Health's rules, standards, and policies as they now exist or as they may be modified, added to, or abolished in the future. I agree to comply with the follow these rules, standards, and policies.
4. To purchase and wear the designated volunteer uniform and ID at all times while volunteering in the medical facility.
5. I certify that the answers given by me to the foregoing questions are true and without omissions. I authorize UCLA Health to investigate and/or verify any information relevant to my suitability as a volunteer.
6. Any person giving misleading or false information will be subject to immediate termination.

Applicant signature: _____ Date: _____

PARENT CONSENT

For youth volunteers (ages 15-17), parental consent is required.

The information contained in this application is correct. I am aware of the various tasks that my daughter/son will be required to perform. My daughter/son has my permission to serve as a volunteer at UCLA Health, and to also obtain Live Scan Fingerprinting/Background Check prior to volunteering. I give permission for my daughter/son to receive all necessary tests and/or vaccinations, including TB tests, as part of her/his health clearance for volunteer work within UCLA Health.

I understand the responsibility my son/daughter is taking on and will encourage his/her promptness and regular attendance as promised.

Parent signature: _____ Date: _____