

UC DAVIS

HEALTH SYSTEM

Thank you for your interest in volunteering with UC Davis Health System.

We offer a wide variety of volunteer opportunities for you to choose from. Volunteers are part of the health team at UC Davis Health System and we are looking for people who are willing to make a firm commitment of their time and talents to our volunteer program.

Please review the volunteer requirements on the web site. If you are ready to get involved at this time, please fill out the application, print it and mail to:

UC Davis Health System, Volunteer Services

2330 ½ Stockton Boulevard
Sacramento, California 95817

We will mail you information to an upcoming mandatory orientation following the return of your application to our office.

UC Davis students, please contact the UC Davis Internship and Career Center at 530-752-2855 for placement information.

We appreciate your interest in our volunteer program and your willingness to give your time and energy.

Sincerely,

UC Davis Health System, Volunteer Services
(916) 734-2401
volunteer.services@ucdmc.ucdavis.edu

UNIVERSITY OF CALIFORNIA, DAVIS, HEALTH SYSTEM
VOLUNTEER SERVICES

Vol ID# _____

PLEASE PRINT

DATE _____

Last Name First Name Initial

HOME ADDRESS _____
Street (include apartment number) City State Zip

E-MAIL ADDRESS (please PRINT clearly)

HOME PHONE _____ CELL / WORK PHONE _____

NOTIFY IN CASE OF EMERGENCY: Name _____

Relation Home Telephone Cell / Work Telephone

Volunteer Area Preference: 1) _____ 2) _____ 3) _____

Time Available: Days _____ Hours _____

How did you hear about volunteering at UC Davis Health System?

- employee (1) volunteer (3) friend (5) just called (9) just knew (10) relative (12)
 high school (20) college (21) other _____

What skills can you offer while volunteering?

I would like to volunteer at UC Davis Health System because (**CHECK ONE ONLY**):

- I want to help patients/hospital
 I am looking for job experience
 I am/will be a student/doing career exploration

Have you volunteered at UCDCM before? _____ Date(s) _____

FOR STUDENTS: Name of School currently attending _____

(Providing this data is voluntary. Noncompletion of this section will not preclude, enhance or detract from your opportunity to volunteer with the UC Davis Health System.)

DATE OF BIRTH _____

M/F _____

RACE/ETHNICITY (Please check one)

American Indian/Alaskan Native

____ (C) American Indian/Alaskan native

(please specify tribal affiliation: _____)

Asian/Pacific Islander

____ (2) Chinese/Chinese American

____ (L) Filipino/Philippino

____ (R) East Indian/Pakistani

____ (B) Japanese/Japanese American

____ (X) Other Asian (Including Far East, Korea, Southeast Asia or Pacific Islands, Samoa)

Black/African American

____ (A) Black/African American (Not of Hispanic origin)

Hispanic (Includes Black individuals whose origins are Hispanic)

____ (5) Latin American/Latino (Including Cuban and Puerto Rican)

____ (E) Mexican/Mexican American

____ (W) Other Spanish/Spanish American

White/Caucasian

____ (F) White/Caucasian (Including the Middle East)

I AM WILLING TO UPHOLD THE PURPOSE OF VOLUNTEER SERVICES which is to render service and support to the hospital, patients, and community served by the University of California, Davis, Health System, in accordance with the objectives established by that institution. IF ACCEPTED AS A HOSPITAL VOLUNTEER, I AGREE THAT I shall hold as absolutely confidential all information that I may obtain directly or indirectly concerning patients, doctors, or personnel, and not seek to obtain confidential information from a patient. MY SERVICES ARE DONATED to the hospital without payment or promise of future employment. FURTHER, I AGREE THAT I will sign in and out in the appropriate method for all hours volunteered.

UCDHS provides medical treatment coverage for a volunteer who sustains an injury/illness in the scope of providing volunteer services to UCDHS. Primary care treatment will be provided by Employee Health Services.

Volunteer Services Department reserves the right to release a Volunteer at will for but not limited to:

- Failure to comply with hospital policies, rules and regulations.
- Unsatisfactory attitude, work or appearance.
- Continuous absences without prior notification **and/or** 3 absences.
- Breach of confidentiality.

Have you been convicted of a felony or a misdemeanor which resulted in imprisonment? Yes No
Please explain circumstances, places and dates.

Signature

Please list employment, school or volunteer activities for the past five years.

OFFICE USE ONLY

Placement Orientation Date: _____

Department Name _____ Cost Center/Code _____ Pay Code _____

S M T W Th F Sa / Time _____ First working day _____

Individual placement: Y N Send letter: Y N

2nd Placement

Department Name _____ Cost Center/Code _____ Pay Code _____

S M T W Th F Sa / Time _____ First working day _____

Waiting List #1

Department Name _____

Day preferred, if any: S M T W Th F Sa

Time preferred, if any _____

Waiting List #2

Department Name _____

Day preferred, if any: S M T W Th F Sa

Time preferred, if any _____