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## ***VOLUNTEER APPLICATION***

**MT. WASHINGTON  
PEDIATRIC HOSPITAL, INC.**  
An affiliate of North Arundel Health System, Inc.

1708 W. Rogers Avenue  
Baltimore, Maryland 21209  
(410) 578-8600



**PROVIDING REHABILITATION  
AND SPECIALTY CARE  
FOR CHILDREN**



**EDUCATION  
AND  
TRAINING**

**CIRCLE HIGHEST GRADE COMPLETED:**

GRADE SCHOOL

HIGH SCHOOL

COLLEGE

GRADUATE

1 2 3 4 5 6 7 8 9 10 11 12

1 2 3 4

1 2 3 4

SCHOOL OR PROGRAM	NAME	LOCATION	DATES ATTENDED FROM / TO	DEGREE OR MAJOR
HIGH SCHOOL				
COLLEGE (UNDERGRAD)				
COLLEGE (GRADUATE)				
APPRENTICE-SHIPS				
BUSINESS OR VOCATIONAL				

OTHER SPECIAL SKILLS OR TRAINING (E.G., HEALTH CARE, BUSINESS OR INDUSTRIAL EQUIPMENT OPERATED, SPECIAL COURSES, FLUENCY IN FOREIGN LANGUAGE, ETC.)

TYPING: APPROXIMATELY \_\_\_ WPM    SHORTHAND: APPROXIMATELY \_\_\_ WPM

**REFERENCES**

LIST AT LEAST THREE (3) REFERENCES THAT ARE NOT RELATIVES OR EMPLOYERS:

NAME	RELATIONSHIP	COMPANY NAME AND ADDRESS	PHONE

**PRESENT  
EMPLOYMENT,  
IF APPLICABLE**

NAME AND ADDRESS OF EMPLOYER: \_\_\_\_\_

EMPLOYER'S PHONE: \_\_\_\_\_ DATE HIRED: \_\_\_\_\_

NAME AND TITLE OF SUPERVISOR: \_\_\_\_\_

TITLE/POSITION: \_\_\_\_\_ WORK HOURS: \_\_\_\_\_

HAVE YOU EVER BEEN CONVICTED OF A SERIOUS CRIME?       NO       YES

IF YES, EXPLAIN FULLY: \_\_\_\_\_

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PLEASE NOTE: IT IS THE HOSPITAL'S POLICY TO CONSIDER THE NATURE, CHARACTER, DATE AND SEVERITY OF INDIVIDUAL CONVICTIONS, AND TAKE INTO ACCOUNT ANY REHABILITATION OR EXTENUATING CIRCUMSTANCES OF THE OFFENCE, AND HOW IT RELATES TO THE JOB, PRIOR TO RENDERING A DECISION ON PROSPECTIVE VOLUNTEERING.

DO YOU HAVE ANY PHYSICAL OR EMOTIONAL LIMITATIONS THAT MUST BE CONSIDERED WHEN PLACING YOU IN A VOLUNTEER POSITION?       NO       YES

IF YES, EXPLAIN FULLY: \_\_\_\_\_

***Please Read and Sign The Following Statement:***

I hereby affirm that all statements and answers made in connection with this application, and any subsequent inquiries requested, are true and correct. It is understood and agreed that any willfull misrepresentation by me will be sufficient cause for cancellation of the application and/or separation from the hospital's service at any time after I have begun to volunteer. I give Mt. Washington Pediatric Hospital, Inc., permission to contact employers, supervisors, and any other source concerning my activities, and I hereby release such reference sources from any liability for the consequences of information which they may release to Mt. Washington Pediatric Hospital, Inc.

Applicant's  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Mt. Washington Pediatric Hospital, Inc.,  
in conjunction with applicable laws,  
does not discriminate on the basis of race, color,  
religion, national origin, sex, age, physical or mental handicap,  
or Veteran status in the selection and placement of volunteers.**