

Masonic Healthcare Center
An Affiliate of Masonicare
22 Masonic Avenue
P. O. Box 70
Wallingford, CT 06492

Rosemarie Preneta
Director of Volunteer Services
203/679-5980

APPLICATION FOR VOLUNTEER SERVICE

Name: _____ Telephone (Home) _____
(Business) _____
Email: _____ (Cell) _____

Street: _____ City: _____ Zip: _____

Education: High School _____ College _____ Degree _____

Training, Experience, or Interest in:

- | | |
|-----------------------------------|----------------------------------|
| _____ Arts & Crafts | _____ Oil Painting |
| _____ Baking | _____ Photography/Videotape |
| _____ Ceramics | _____ Physical Therapy |
| _____ Clerical | _____ Recreation |
| _____ Computers | _____ Transporting by wheelchair |
| _____ Games | _____ Visiting Residents |
| _____ Gift Shop/Convenience Store | _____ Writing |
| _____ Horticulture | _____ Other |
| _____ Library | _____ |
| _____ Nursing | |

Previous experience (Paid or Volunteer): _____

Time you have available: Monday Tuesday Wednesday Thursday Friday
Saturday Sunday Flexible/Morning/Afternoon/Evening

Reference: _____

In case of emergency notify _____ Telephone _____

FOR OFFICE USE ONLY:

Interview: _____ Orientation: _____ Tour: _____
Assignment: _____ Pin: _____ Computer: _____

1. Please note any physical limitations:

2. My physician is: _____

Address: _____

3. Please list any medications, such as insulin, blood pressure pills, or heart medicine, taken regularly:

4. I understand that if I have an illness that prevents me from volunteering for an extended period of time, on my return, I will provide Masonic with a signed statement from my physician stating my ability to resume volunteer work.

Signature

Date