

Volunteer
ID# _____

Office Use Only:	
Date Received:	_____
Entered By:	_____
R1 _____	SB _____
R2 _____	BC _____



ADULT VOLUNTEER APPLICATION - Stitcher

(PLEASE PRINT)

Last Name	First Name	Middle Name
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Mr. Ms. Mrs. Miss Dr. Other _____ Preferred Nickname: _____

Home Address

Street Address (Not a P.O. Box)	Apartment Number
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City	State	Zip Code
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Is anyone else at this address already a volunteer here? No Yes If Yes, what is their name? _____

Have you ever served as a volunteer with us before? No Yes If Yes, in what year(s)? _____

Home Phone Number ()	Business Phone -or- Cell Number ()	E-mail Address
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I prefer to be contacted at: Home Business Cell E-Mail

Personal Information

Emergency Contact Name and Phone Number ()	Relationship
(optional) List allergies and any other health concerns that staff should know.	
(optional) Ethnicity: <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Pacific Islander	

I am age 18 or older Birthdate: ____/____/____ (mm/dd/yyyy)

Reasons you'd like to become a volunteer . . .

What attracted you to seek a volunteer opportunity with Cook Children's?

Where did you learn about the volunteer opportunities at Cook Children's? (check all that apply)

<input type="checkbox"/> Cook Website	<input type="checkbox"/> Radio/TV	<input type="checkbox"/> As a Cook parent
<input type="checkbox"/> Other Website: _____	<input type="checkbox"/> Family/friend	<input type="checkbox"/> As a Cook patient
<input type="checkbox"/> Newspaper	<input type="checkbox"/> Cook volunteer	<input type="checkbox"/> Other: _____

CONFIDENTIALITY STATEMENT - Please read carefully before signing

I understand and agree that in the performance of my duties as a volunteer of Cook Children's Health Care System I must hold in strictest confidence any observations I may make or information I may hear regarding patients, patient families, or staff.

I verify that all of the information provided by me on this application is true, correct, and complete. I grant Cook Children's permission to verify this information in arriving at a volunteer decision. I understand that false or misleading statements or the omission of any information necessary to make this application complete will result in rejection of my application.

Applicant's Signature: _____ Date: _____

Please send to:

Marie Howell, Volunteer Program Manager
Cook Children's Medical Center
801 Seventh Ave, Fort Worth, TX 76104

fax: 682.885.7480
office: 682.885.7452
email: marieh@cookchildrens.org

www.dfwstitchawish.com