Dear Prospective Volunteer:

Thank you for your interest in volunteering at **Memorial Hospital Pembroke**. We are pleased that you have chosen our hospital.

All volunteers are required to give a minimum of a four-hour shift per week within a six-month commitment. In addition, the following will be required:

- Government Issued ID
- Letter of recommendation (for teens 15y/o- 17y/o)
- Background check (Conducted by Memorial Healthcare System)
- Tuberculosis Screening (Provided by Memorial Healthcare System)
- Flu vaccine required during Flu season (Oct 1st-March 31st)
- Complimentary uniform (Jacket)
- Attend a new volunteer orientation.

IMPORTANT: For a successful application submission, follow the steps below:

1. Download this file/application, complete the form below, sign, and date.
2. Save the PDF application on your electronic device.
3. Attach all required documents in PDF format to email: MHPVolunteer@mhs.net
   Please include the letter of recommendation (for teens only) and a copy of your government-issued ID.

Note: We do not accept Court-Ordered Community Service.

Applicants will be accepted based on an interview and the needs of the hospital. If you have any questions, please contact the Volunteer Services Department at **954-883-7000.**

Again, thank you for your interest in joining our Memorial Healthcare System Team.

Sincerely,

Volunteer Services Department
Memorial Hospital Pembroke
7800 Sheridan St.
Pembroke Pines, FL 33024

Volunteer Application

Name Last:*	First:*	M.I.:
Address:*		
City:*	State:*	Zip:*
Primary Number:*	Cell Number:*	
Are you between the age of 15yrs. -17yrs.?*	☐ Yes ☐ No	
Applicant's E-mail address:*		
Emergency Contact Name:*	Relationship:*	Phone Number:*
Previous/Current Occupation:		
School currently attending:		
Special abilities/skills:		
Do you speak/write an additional language? If yes, please indicate the language(s):		
Please list any prior volunteer experience you have:		
Please list any duties you're unable to perform?		
How did you hear about our volunteer program: Do you have any friends or family affiliated with MHS?		
What are you hoping to gain from your volunteer experience?		

***PLEASE CHECK THE TIMES AND DAYS YOU ARE AVAILABLE TO VOLUNTEER**

TIME	MON	TUE	WED	THU	FRI	SAT	SUN
9AM - 1PM							
1PM – 5PM							
4PM – 8PM							

PLEASE SELECT THE AREA YOU WOULD LIKE TO VOLUNTEER IN
(Please note that each hospital site has different areas of opportunity)

Gift Shop: ______ Peds/Adult Emergency Room:______ Greeter:_____Rehab:______
Clerical:_________ Nurses Station:______ Environmental Services: ______
Food Service ______ Central Supplies________ Other__________

Signature:* ______________________ Print Name:*

Parent / Legal Guardian Signature:
(Required if 17 years of age and under) ______________________________

Please note we do not provide court ordered community service hours.

Agreement to Conduct a Background Check

☐ *By clicking the 'checked' box, I understand and agree that as a part of the application process to be considered for a volunteer position at Memorial Healthcare System, Memorial Healthcare System will conduct a criminal background check. I agree that if I am accepted to the volunteer program, and if any information I have provided is found to be false or misleading in any way, I may be subject to dismissal from the program.

Signature:* **Date:***

Parent Signature:* **Date:***

(Required if 17 years of age and under)

Note: All (*) fields are required