**MERCY MEDICAL CENTER - NEW HAMPTON**
**VOLUNTEER / JOB SHADOW INFORMATION FORM**

**PLEASE PRINT** **Date**_____

**NAME**_____ **PHONE**_____

**ADDRESS**_____
**Street** **City** **State** **Zip**

**NAME/PHONE OF NEAREST RELATIVE**_____
**Name** **Phone**

**EMAIL :**_____

**Work Experience** &/or **Volunteer Experience** (Start with most recent)

| | |
|---|---|
| Employer:_____ | Employer:_____ |
| Address:_____ | Address:_____ |
| Phone:_____ | Phone:_____ |

Describe any special training, skills, interests or hobbies

**VOLUNTEERS**: Check the type of volunteer work you are interested in doing at Mercy Medical Center:

- ☐ Outpatient waiting room volunteer (times may vary, once or twice a month)
- ☐ Business mail distribution (1-2 hours every 2 weeks)
- ☐ Office work / making copies / mass mailing preparation, etc. (times may vary)
- ☐ Blood Drive / Wellness Screening
- ☐ Other

What day and time would you be available to volunteer or job shadow?

| Day(s): | Time (s): |
|---|---|
| _____ | _____ |
| _____ | _____ |

**JOB SHADOOW PARTICIPANTS:**

School currently attending:_____
Future / career interests:_____

**Personal References**

| | | |
|---|---|---|
| Name:_____ | Name:_____ | Name:_____ |
| Address:_____ | Address:_____ | Address:_____ |
| Phone:_____ | Phone:_____ | Phone:_____ |

Why would you like to volunteer or job shadow at Mercy Medical Center - New Hampton?