

**Trinity Health System  
Adult Volunteer Application**

NAME \_\_\_\_\_ DATE \_\_\_\_\_

(Last) (First)  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

BIRTH DATE \_\_\_\_\_  
(YEAR OPTIONAL) \_\_\_\_\_ HOME PHONE \_\_\_\_\_

IF EMPLOYED, NAME AND PHONE NUMBER \_\_\_\_\_  
CONTACT IN CASE OF EMERGENCY:

\_\_\_\_\_  
(name) (relationship) (home phone)

FAMILY PHYSICIAN \_\_\_\_\_  
(number)

LIMITATIONS RELATED TO HEALTH \_\_\_\_\_

HAVE YOU VOLUNTEERED FOR THIS ORGANIZATION BEFORE? YES \_\_\_ NO \_\_\_

EDUCATION \_\_\_\_\_

WORK EXPERIENCE \_\_\_\_\_

VOLUNTEER EXPERIENCE \_\_\_\_\_

INDICATE HOBBIES/SKILLS/SPECIAL INTEREST/FOREIGN OR SIGN  
LANGUAGE SKILLS: \_\_\_\_\_

E – mail address \_\_\_\_\_

PLEASE GIVE ANY OTHER INFORMATION YOU FEEL PERTINENT TO YOUR  
APPLICATION \_\_\_\_\_

PLEASE INDICATE IF YOU WOULD PREFER TRINITY EAST \_\_\_\_\_ WEST \_\_\_\_\_ OR  
BOTH \_\_\_\_\_

The above information is accurate and correct to the best of my knowledge.  
Opportunities for volunteers are provided without regard to religion, creed, race, origin,  
age or sex.

**By initialing and signing below,**

\_\_\_\_\_ I give my consent for my name, birth date, and photo or likeness (copied photo,  
scanned and or digitized) to be published in news articles, newsletters and all other  
marketing formation.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_