Cooley Dickinson Health Care Corporation
www.cooley-dickinson.org

VOLUNTEER APPLICATION

30 Locust Street
P.O. Box 5001
Northampton, MA 01061
Volunteer Services (413)-582-2251
Fax: 413-582-2951
robin_kline@cooley-dickinson.org

Date:_____

It is the intent of the CDHCC to conform to Federal and State Laws pertaining to non-discrimination.

Mr. Miss. Mrs. Ms. Last Name: First Middle	Home Phone:
	Business/Cell Phone:
Address: No. Street City State Zip	Email:

In case of emergency notify:

Name:	Address:
Relationship:	**Phone:**

What do you hope to gain from your volunteer experience?		
What is your current occupation?		
Please describe any prior or present volunteer or community activities:		
Please list any skills, hobbies or interests which will help us place you appropriately:		
Have you ever volunteered at CDH before? If yes, when?	☐ Yes ☐ No	Please note best days and times:
Were you ever employed by CDHCC?	☐ Yes ☐ No	
Are you a member of the CDH Auxiliary?	☐ Yes ☐ No	
Are you a member of RSVP?	☐ Yes ☐ No	

Please note best days and times:	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
8-12	☐	☐	☐	☐	☐	☐	☐
12-4	☐	☐	☐	☐	☐	☐	☐
4-8pm	☐	☐	☐	☐	☐	☐	☐

STUDENTS ONLY	
School:	Major:
Is this an Internship for credit? ☐ Yes ☐ No	How many TOTAL hours are required?
Commitment Level: Entire School Year ☐ Summer only☐ Semester ☐ Circle one: Fall Spring	
Year in School: Circle one: Freshman Sophomore Junior Senior	
Are you under 15 years of age? ☐ Yes ☐ No	

References (Do not include relatives)

Name:	Complete Address	Business/Occupation:

Previous Employment: List most recent first.

Name & Address:	Position & Duties:	Dates:
1.		From To
2.		From To
3.		From To

Name of School	Course of Study	Graduated?
High School:		
College/University:		
Other Schools:		

Have you ever been the subject of any disciplinary or corrective action or conduct or performance by any authorized oversight agency? ☐ Yes ☐ No

Have you ever been sanctioned or excluded or been the subject of a sanction or exclusion proceeding by Medicare, Medicaid or other federal health care program? ☐ Yes ☐ No

Please Read Carefully

All of the above statements are true to the best of my knowledge. Any misstatements are sufficient cause for my dismissal. I authorize The Cooley Dickinson Health Care Corporation to verify any information presented in this form and to request statements from references. In the event of my volunteering for the Cooley Dickinson Health Care Corporation, I agree to comply with all of The Cooley Dickinson Health Care Corporation's rules and regulations as they may be changed from time to time.

Signature:_____ Date:_____