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, volunteers will require the following:

- Government-issued ID
- Letter of recommendation (for teens 15yrs. to 17yrs. old)
- Background check (provided by Memorial Healthcare System)
- Tuberculosis Screening (provided by Memorial Healthcare System)
- Flu vaccine required during flu season. (October 1st – March 31st)
- Complimentary Uniform
- Attend a new volunteer orientation

Please complete and click the submit button at the bottom of the application. In addition, send your letter of recommendation to MHPVolunteer@mhs.net.

Please note we do not accept Court-Ordered Community Service.

Applicants will be accepted based on an interview and the hospital's needs. Please contact the Volunteer Services Office at 954-538-4640 if you have any questions before completing the Volunteer Application.

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

Memorial Healthcare System

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

SUBMIT