

**NIH Clinical Center Summer Volunteer Application – please print or type**

NAME: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: Home ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

BIRTH DATE: \_\_\_\_\_

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**PREFERRED WORK AREA: (Circle)**

Administrative      Patient Contact      Research      Other \_\_\_\_\_

<b>HOURS AVAILABLE/WANTED:</b>	<b><u>DAY</u></b>	<b><u>HOURS AVAILABLE</u></b>
Number of days per week: _____	Monday	_____
Hours per day: _____	Tuesday	_____
Start Date: _____	Wednesday	_____
	Thursday	_____
	Friday	_____

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**WORK EXPERIENCE: (Paid or volunteer; list current or most recent job first.)**

**1. Job Title** \_\_\_\_\_ **Dates** \_\_\_\_\_

Company Name \_\_\_\_\_

Supervisor \_\_\_\_\_ Phone \_\_\_\_\_

Duties \_\_\_\_\_

Reason for Leaving \_\_\_\_\_

**2. Job Title** \_\_\_\_\_ **Dates** \_\_\_\_\_

Company Name \_\_\_\_\_

Supervisor \_\_\_\_\_ Phone \_\_\_\_\_

Duties \_\_\_\_\_

Reason for Leaving \_\_\_\_\_

**3. Other Jobs/Experience:**

\_\_\_\_\_  
\_\_\_\_\_

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**SKILLS/HOBBIES: (Circle all that apply)**

Data Entry    Computer (Microsoft Office)    Filing    Organizing    Telephone    Customer Service  
Other: \_\_\_\_\_

**WHY DO YOU WANT TO VOLUNTEER?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**AREAS OF INTEREST/CAREER GOALS:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**EDUCATION:**

Currently enrolled? Yes  No  Last Grade Completed: 8 9 10 11 12 College: Fr So Jr Sr

Name of High School \_\_\_\_\_ Graduated: Yes No

Name of College \_\_\_\_\_ Graduated: Yes No

Degree/Major(s) \_\_\_\_\_

Other Training \_\_\_\_\_

**HOW DID YOU FIND OUT ABOUT VOLUNTEERING AT THE NIH?**

Employee (Name) \_\_\_\_\_ Church Bulletin  Advertisement

Volunteer Organization (Name) \_\_\_\_\_ CC Webpage

Volunteer (Name) \_\_\_\_\_ Other (*Specify*) \_\_\_\_\_

**HAVE YOU EVER VOLUNTEERED AT THE NIH?** Yes No

Year(s) \_\_\_\_\_ Name (*if different*) \_\_\_\_\_

Area(s) \_\_\_\_\_ Supervisor? \_\_\_\_\_

**WILL YOU PARK YOUR VEHICLE AT THE HOSPITAL?** Yes No **METRO/Bus?** Yes No

**EMERGENCY CONTACT:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Work/Cell ( ) \_\_\_\_\_

**HEALTH SURVEY**

Date of last TB Skin Test \_\_\_\_\_ Reaction:  Negative (no reaction)  Positive (swollen, red)

*Check those that apply to you and elaborate, if needed.*

- |  |   |
|--|---|
| <input type="checkbox"/> Back Problems     | <input type="checkbox"/> Blind                          |
| <input type="checkbox"/> Diabetic          | <input type="checkbox"/> Epilepsy                       |
| <input type="checkbox"/> Hearing Impaired  | <input type="checkbox"/> Mental Health                  |
| <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Other ( <i>Specify</i> ) _____ |

I verify the information on this application is correct.

\_\_\_\_\_  
*Signature of Applicant and Date*

\_\_\_\_\_  
*Signature of Parent/Guardian (under 18 years only) and Date*

**FOR OFFICE USE ONLY**

INTERVIEW \_\_\_\_\_ ORIENT \_\_\_\_\_ ASSIGN \_\_\_\_\_ SUPERVISOR \_\_\_\_\_