Patient Ambassador Application – *please print or type*

NAME: (Last) (First) (MI)

TITLE: Dr. Mr. Mrs. Miss Ms. **E-Mail Address:**

STREET ADDRESS:

CITY: **STATE:** **ZIP:**

PHONE: Home Work
School Cell

BIRTH DATE:

PREFERRED WORK AREA: (*Circle*)
Medical Records (Available 6am-10am & 4pm-8pm) Imaging (Available 7am-3pm) Surgery (Available 6am-10am)

AVAILABILITY:

Number of days per week 1 2 3 4 5

Hours per day: 4 6 8

Start Date:

DAY	**HOURS AVAILABLE**
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	

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

Current Status (*Circle one*) Retired Unemployed Employed Student

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: (*List job titles only.*)

REFERENCES:

Name	Phone	Email
1.		
2.		

LANGUAGES SPOKEN: *(Circle)* English French Spanish Italian Other:

SKILLS/HOBBIES: (*Circle all that apply*)
Data Entry Word Processing/Typing Filing Organizing Telephone
Other:

WHY DO YOU WANT TO VOLUNTEER? (*Check all that apply*)
Retired Experience School Requirement Give Back to Community
Path to Become Employed Other (*Please specify*)

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) Red Cross

Volunteer (Name) Other (*Specify*)

HAVE YOU EVER VOLUNTEERED AT THE NIH? Yes No
Year(s) Name (*if different*)
Area(s)

WILL YOU PARK YOUR VEHICLE AT THE HOSPITAL? 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.

- ☐ Back Problems
- ☐ Diabetic
- ☐ Hearing Impaired
- ☐ Tuberculosis (TB)
- ☐ Blind
- ☐ Epilepsy
- ☐ Mental Health
- ☐ Other (*Specify*)

I verify that the information on this application is correct.

Signature of Applicant *Date*

● ●

FOR OFFICE USE ONLY
REC____________ CL_____________ DVS_____________ INTERVIEW _____________ / _______________