



LAC+USC MEDICAL CENTER  
VOLUNTEER SERVICES  
2051 MARENGO ST., Building H, Room 1K311  
LOS ANGELES, CA 90033  
(323) 409-6945



## Adult Volunteer Minimum Requirements

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- Completed application
- Students must be currently enrolled in college, attach the following documents to the application:
  - 1) Unofficial Transcripts (minimum 2.75 GPA)

**OR**

Certification of successful completion of university/college studies  
(University/college Diploma)

  - 2) Letter of recommendation (Non-related, 1 minimum)
- Non-students (Not currently enrolled in a higher education institution)
  - 1) Letter of recommendation (Non-related, 1 minimum)
- Must be able to successfully complete a background check (scheduled after interview)
- Must be able to successfully complete Health Clearance (scheduled after interview)
- Must be willing to dedicate a minimum of 200 hours (4 hours per-week minimum)
- Applicants are highly encouraged to include any additional documents that may strengthen application (i.e. resume/CV, AA Degree, Certifications, Awards/Honors, etc.)

Please submit application via email to

**[volunteerservices@dhs.lacounty.gov](mailto:volunteerservices@dhs.lacounty.gov)**

### **Description of Programs for Adult Volunteers**

**DEM (Department of Emergency Medicine Volunteers):** This program is reserved for University/Community College/ Trade School/ Skill Center students or graduates interested in perusing a career in the medical field. DEM volunteers provide support to RNs, PAs, and MDs within the Department of Emergency Medicine, a 142+ bed unit. These volunteers perform a variety of functions that support the roles of patient care and family support.

**GA (General Adult Volunteers):** Volunteers in this program provide a variety of general services such as, patient transport, throughout departments within the medical center. Volunteers in this program may be placed in both clinical and non-clinical settings in order to provide support to RNs, PAs, and MDs in effort of providing support for the roles of patient care and family support.

OFFICE USE ONLY
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ADULT VOLUNTEER APPLICATION (PLEASE PRINT IN BLACK OR BLUE INK)

DATE:

1. LAST NAME		FIRST NAME		M.I.	SOCIAL SECURITY #		GENDER F M		DATE OF BIRTH				
2. HOME ADDRESS (BDG / APT / UNIT / RM)				CITY			STATE		ZIP				
3. HOME PHONE #			BUSINESS PHONE #			CELL PHONE #			E-MAIL ADDRESS				
4. MEDICAL INSURANCE PROVIDER / POLICY #						PRIMARY PHYSICIAN			PHONE #				
5. SCHOOL PREVIOUSLY OR CURRENTLY ATTENDING			CITY, STATE		GPA (IF APPLICABLE)		GRAD YEAR (IF APPLICABLE)		MAJOR / DEGREE (IF APPLICABLE)				
6. PREVIOUS VOLUNTEER EXPERIENCE				DUTIES				LENGTH OF TIME					
7. WHICH HEALTH CARE DISCIPLINE ARE YOU INTERESTED IN? IF NOT HEALTH CARE, WHAT IS YOUR CAREER GOAL?						8. LIST ANY PERSONAL HOBBIES / SPORTS:							
7A. WHICH VOLUNTEER PROGRAM ARE YOU INTERESTED IN? (REFER TO PAGE ONE FOR DESCRIPTION)						<input type="checkbox"/> DEPARTMENT OF EMERGENCY MEDICINE VOLUNTEER <input type="checkbox"/> GENERAL ADULT VOLUNTEER							
9. WHY DO YOU WISH TO VOLUNTEER AT THE LAC+USC MEDICAL CENTER?													
11. NAME OF FRIEND OR RELATIVE EMPLOYED OR VOLUNTEERING AT LAC+USC:						10. LIST ANY TECHNICAL AND/OR CREATIVE SKILLS / TALENTS YOU MAY HAVE:							
12. PROPOSED SCHEDULE (LIST TIME SLOT AVAILABILITY; MINIMUM OF ONE 4 HOUR SHIFT PER WEEK):													
MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY		SUNDAY	
13. LIST TWO (2) EMERGENCY CONTACTS:													
NAME			RELATIONSHIP			HOME PHONE #			BUSINESS PHONE #		CELL PHONE #		
NAME			RELATIONSHIP			HOME PHONE #			BUSINESS PHONE #		CELL PHONE #		

14. PRESENT / LAST EMPLOYER			PAYROLL TITLE		LENGTH OF EMPLOYMENT	
ADDRESS	CITY	STATE	PHONE #	PRESENT EMPLOYER? IF NO, STATE REASON FOR LEAVING. IF YES, MAY WE CONTACT YOUR EMPLOYER?		
				YES	NO	
15. HAVE YOU EVER BEEN FIRED OR ASKED TO RESIGN? IF YES, PLEASE ATTACH AN EXPLANATION WITH THE NAME AND ADDRESS OF THE COMPANY, AND THE DATE AND REASON FOR THE TERMINATION.					YES	NO
16. HAVE YOU EVER BEEN CONVICTED OF A MISDEMEANOR OR FELONY BY A CRIMINAL OR MILITARY COURT? IF YES, PLEASE COMPLETE THE RECORD OF CONVICTIONS SECTION BELOW. LIST ALL CONVICTIONS. ATTACH AN ADDITIONAL SHEET IF NECESSARY.					YES	NO
OTHER NAMES USED:			DATE OF BIRTH:	SOCIAL SECURITY #		
OFFENSE OR CASE NAME (INDICATE PENAL OR OTHER CODE SECTION IF KNOWN):						
CASE NUMBER:			LOCATION OF COURT (CITY / STATE):			
CONVICTION / ORDER DATE:			SENTENCE OR FINE:			

● I HEREBY CERTIFY UNDER PENALTY OF PERJURY THAT ALL STATEMENTS MADE IN CONNECTION WITH THIS APPLICATION FOR VOLUNTEER WORK ARE TRUE TO THE BEST OF MY KNOWLEDGE. I HEREBY AUTHORIZE THE LAC+USC HEALTHCARE NETWORK VOLUNTEER SERVICES DEPARTMENT TO OBTAIN RECORDS OF MY CRIMINAL CONVICTIONS FROM THE CALIFORNIA DEPARTMENT OF JUSTICE OR ANY OTHER AGENCY THAT COLLECTS SUCH RECORDS.

● I UNDERSTAND THAT THE PROGRAM I'M APPLYING FOR CONSISTS OF A 200 HOURS MINIMUM COMMITMENT TO .

APPLICANT NAME (PRINT):

SIGNATURE:

DATE:

**FOR OFFICE USE ONLY**

	DATE	BY	COMMENTS
RECEIVED / REVIEWED:	_____	_____	_____
INTERVIEW SCHEDULED FOR:	_____	_____	_____
ACCEPTED / PROGRAM:	_____	_____	_____
ORIENTATION SCHEDULED:	_____	_____	_____