Pediatric Angel Network

Inspiring Hope and Brightening Lives

Dear Applicant,

Thank you for your interest in volunteering with the Pediatric Angel Network. Prospective volunteers must complete the following steps before being interviewed for a volunteer position.

Adults (18 and over)

1. Complete and return application
2. Background check- this will be initiated when application is returned/interview completed and position available.
3. Immunizations up to date as stated by a physician.
4. Complete names and addresses of two references.
5. If position offered you will be notified of an orientation date and time.
6. Schedule and assignment will be discussed at the interview with volunteer able to start after receipt and review of background check.

Juniors (14 through 17)

1. Complete and return application
2. Submit immunizations (can use school medical record)
3. When paperwork is complete an interview will be scheduled and you will be notified of an orientation date and time.
4. Schedule and assignment will be discussed at the interview.

Although we do not have a minimum volunteer requirement, we do ask student volunteers in The PAN Project to please aim to commit to at least 20 hours of service with an assigned child.

Questions please call 800-620-3620.
Fax paperwork to 866-546-7493
Or mail to:

Pediatric Angel Network
Volunteering
POB 213
Mendham, New Jersey 07945

ADULT Volunteer Application

Name _____ **Date:** _____ ☐ *Female* ☐ *Male*
(last) (first) (middle) (maiden)

Address _____
_ **(Street) (City, state) (Zip)**

Birth Date: mo____ **day**___ **yr**_____ **Social Security #** _____

Home Phone: (___**)** _____ **Cell phone:** _____

E-mail:_____ **Have you ever been convicted of a crime?** _____

In an emergency notify: _____

Relationship _____ **Phone (**___**)** _____ **Alternate (**___**)** _____

EDUCATION/WORK EXPERIENCE

Employer _____ Position _____ How long? _____

Work phone (___) _____ May we contact you at work? Yes No

Retired from _____ Position _____

Volunteer experience _____

_____

Languages spoken: _____

Level of education completed _____ _____

Currently attending (name of institution): _____ Last year completed _____

Reasons for Volunteering: _____

Rev. 11/10

JUNIOR Volunteer Application

Name_____ ☐Female ☐ *Male* **Date:**_____
(Last) (First) (Middle)

Address_____
(Street) (City, state) (Zip)

Birth Date: mo____ day____ yr____ **Social Security #** _____

Home Phone: (____) _____ **Cell phone:** _____

E-Mail: _____ **In an emergency notify:** _____

Relationship _____ **Phone (____)** _____ **Alternate (____)** _____

PARENTS' INFORMATION

Mother's Name: _____

Mother's place of business: _____ Phone: _____

Father's Name: _____

Father's place of business: _____ Phone: _____

SCHOOL INFORMATION

School Name: _____ City_____

Phone #: _____

DOCTOR'S INFORMATION

Name: _____ Phone: _____

VOLUNTEER AVAILABILITY

Volunteer job you prefer_____

Place the **HOURS** you are available to volunteer

	MON	TUES	WED	THURS	FRI	SAT	SUN
Morning							
Afternoon							
Evening							

Additional comments, skills, training you would like to share_____

_____

How did you hear about us?_____

Reasons for volunteering_____

_____

_____

_____

Parent/Guardian signature_____Date_____
(For Junior Applicant)

IMMUNIZATION STATUS FORM

PLEASE PRINT

NAME_____

ADDRESS_____

CITY, STATE, ZIP CODE_____

TELEPHONE_____

DATE OF BIRTH _____

Please complete the form below and sign where indicated, thank you.

Status	**IMMUNE**	**NOT IMMUNE**	**DATE of lab test**
Chicken Pox (Varicella)			
Measles (Rubeola)			
German Measles (Rubella)			

VACCINES	**DATE GIVEN**
MMR	
Varivax	

Physician Name (PRINT PLEASE)_____

Physician Signature_____

Date_____

APPLICANT CONSENT FOR BACKGROUND INVESTIGATION

I hereby authorize Pediatric Angel Network Inc. to investigate me, my former employment, and professional reputation.

I hereby authorize all persons, firms, companies, government agencies, courts, credit agencies, associations or institutions having control of my documents, records, or other information to furnish such documents to said requestor.

I hereby release Pediatric Angel Network Inc. from any and all liability resulting from such investigation.

Signature_____ Date_____

References:

You must give the names and complete addresses of two persons with whom you have worked and are not related to you.

1. Name_____

   Address_____

2. Name_____

   Address_____