



PALS VOLUNTEER APPLICATION FORM

Personal Details

| | |
|----------|--------------|
| Name: | DOB: |
| Address: | Tel No.: (H) |
| | (M) |
| | |
| | |
| Email: | |

Who to contact in the case of an Emergency

| | |
|---------------|--------------|
| Name: | Tel No.: (H) |
| Relationship: | Tel No.: (M) |

Why have you chosen to apply to University Hospital Limerick as a Volunteer?

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Please give details of any experience you have of voluntary work:

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What skills, experience and attributes do you feel you can bring to the role?

Availability:

How many hours per week would you like to volunteer for?

We ask for a minimum of one session per week

Please tick when you would be available

| | Morning (9.30-12.30) | Afternoon (1.30-4.30) |
|--|----------------------|-----------------------|
|--|----------------------|-----------------------|

Monday

Tuesday

Wednesday

Thursday

Friday

Is there anything else you wish to tell us about yourself? Please use the space below or a separate sheet if necessary:

| Where did you hear about our Volunteering programme? | |
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| In the media | |
| The Volunteer Centre | |
| Word of mouth | |
| Used the service | |
| Other (Please specify) | |

| References: |
|---|
| Please provide us with the names of two people over the age of 18, not related to you, who can provide you with references. These can be employers or anyone else who would be able to comment on your suitability for this volunteer role. |

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|-------------|---------------|
| 1. Name: | |
| Address: | |
| | |
| | |
| Occupation: | Relationship: |
| Tel No.: | Email: |

| | |
|-------------|---------------|
| 2. Name: | |
| Address: | |
| | |
| | |
| Occupation: | Relationship: |
| Tel No.: | Email: |

| Garda Vetting |
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All volunteers will undergo Garda vetting. Are you willing to submit your name for vetting if offered a volunteer role? Please circle: Yes No

| Declaration |
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I declare that the information given on this application form is true and complete to the best of my knowledge. I understand that any offer of placement made may subsequently be withdrawn or terminated should any of the information be found to be untrue.

Signature: _____ Date: _____

Thank you for completing this application form. Please sign and return to:
 Niamh Hogan
 Patient Advocacy & Liaison Services (PALS) Manager, 2nd Floor Nurses Home,
 University Hospital Limerick, Dooradoyle, Limerick.