Volunteer Request/Description Form

POSITION TITLE: 
REQUEST/UPDATE DATE: 

DEPT: 
LOCATION: 

REQUESTED BY: 
PHONE #: 

STAFF PERSON RESPONSIBLE FOR TRAINING: 

START DATE: 
END DATE: 

# OF VOLUNTEERS NEEDED: 
DAYS/HOURS: 

COMPETENCIES/QUALIFICATIONS: (i.e. Physical Requirements, Minimum Education, Skills, etc.)

- 
- 
- 

TRAINING: Completion of one-on-one training with departmental supervisor. Please be advised that the volunteer supervisor must provide one-on-one training for the volunteer before he or she begins service.

DUTIES/RESPONSIBILITIES: (i.e. Activities performed by the volunteer during the course of their services)

- 
- 

(Highlight in Bold all that apply below)

POSITION TYPE: Administrative/Clerical Laboratory Patient Contact Research SOM

Will your volunteer have contact with patients? Yes No

Please circle the type of Patient Information your volunteer will encounter during the course of their services:
- Name
- Address
- Date of Birth
- Admission Date
- Discharge Date
- Telephone#
- Fax#
- Finger or Voice Prints
- Web URL
- Email Address
- Social Security #
- Medical Record #
- Health Plan Beneficiary #
- Account#
- Certificate/License #
- Vehicle Serial #
- Device Identifiers or Serial #
- Photographic Images
- Any characteristics that uniquely identify patient

Will your volunteer speak with patients on the phone? Yes No

Will your volunteer need computer access? Yes No

To what JHMI system/database will your volunteer need access?

Volunteer Name: