

Volunteer Registration Form

Mahalo for your interest and commitment to Waikiki Health.
We look forward to working with you!

WAIKIKI HEALTH

MEDICAL & DENTAL • BEHAVIORAL HEALTH • SOCIAL SERVICES

PERSONAL INFORMATION

Name:

Address:

City:

State:

Zip:

Phone:

Cell:

Work:

Email:

In case of emergency, contact:

Name:

Relationship:

Phone:

PLEASE TELL US YOUR AREA(S) OF INTEREST:

In-office (administrative tasks) Special Events Skills & Experience (painting, gardening, etc.)

Other:

HOW DID YOU HEAR ABOUT OUR VOLUNTEER PROGRAMS?

Word of mouth Advertising Social Media Trade Show Newspaper (article)

Other:

PREFERRED PROGRAMS TO VOLUNTEER:

Youth Outreach: 40 Hours (M-F) - Initial mandatory volunteering; 2 PM – 6 PM (M-F)

Next Step Shelter: 5 PM – 7:30 PM (Sun-M-T-W); or 5 PM – 7:30 PM (Sun-T-W-Thu)

Other:

Please indicate any other information about yourself, your interests, or any special skills that you would like to contribute

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GENERAL WAIVER AND RELEASE: In signing this release, I acknowledge that I hereby agree and will absolve and hold harmless the Waikiki Health, corporate sponsors, cooperating organizations, and any other parties connected with this event in any way, singly or collectively, from and against any blame and liability for any injury, misadventure, harm, loss, inconvenience, or damage hereby suffered or sustained as a result of volunteer services performed on behalf of Waikiki Health. I also hereby consent to and permit emergency treatment in the event of injury or illness.

I certify that I have read this waiver and release and understand its significance.

Signature: _____ Date: _____

I the undersigned, grant permission to Waikiki Health to use my name, picture, and/or likeness in any manner and in any media, without limitation as to the use of my name, picture and/or likeness, either alone or accompanied by other material.

I agree that I will not hold Waikiki Health, singly or collectively responsible for any liability resulting from the use of my name, picture, and/or likeness in the manner described above.

Signature: _____ Date: _____

**Please fax this form to (808-697-6849) or e-mail your completed form to
HR Assistant Micah Gay-ya (egayya@waikikihealth.org).**

If you have any questions, please contact Micah at 808-537-8417.

Mahalo!

The mission of Waikiki Health is to provide quality medical and social services that are accessible and affordable for everyone, regardless of ability to pay.