



## Sunrise on Wheels Volunteer Application

Date of Application: \_\_\_\_\_

### **Personal Information**

Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Permanent Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email address: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer or School: \_\_\_\_\_

Employer / School Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Languages Spoken: \_\_\_\_\_

Education: \_\_\_\_\_

Training or Certifications pertinent to child care: \_\_\_\_\_

\_\_\_\_\_

Do you have any physical limitations? If so, specify: \_\_\_\_\_

Have you ever been convicted of a felony or misdemeanor other than minor traffic offenses? If so, please explain.

\_\_\_\_\_

\_\_\_\_\_

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### **Emergency Contact**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

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**Previous Hospital or Community Volunteer Experience** (Use additional sheets if necessary)

Where: \_\_\_\_\_ When: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Your Role: \_\_\_\_\_

Where: \_\_\_\_\_ When: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Your Role: \_\_\_\_\_

What type of child care experience, if any, do you have? (If babysitting/nanny, please indicate age of child and name of parent/contact info): \_\_\_\_\_

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Do you have any experience in working/volunteering with children with cancer/chronic illnesses/ special needs? Please describe: \_\_\_\_\_

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Why do you want to volunteer in a hospital environment? \_\_\_\_\_

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Please specify what personal skills/characteristics you will bring to Sunrise on Wheels to fulfill the special needs of the children:

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How did you hear about Sunrise on Wheels? \_\_\_\_\_

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**Which of the following hospitals are you interested in joining? (Please check all that apply.)**

The Children's Hospital at Montefiore: (Bronx)

- Mondays 9:30 AM - 12:30 PM
- Mondays 12:30 PM - 3:30 PM

NYU/Langone: (Manhattan)

- Mondays 10:00 AM - 2:00 PM

Mt. Sinai Medical Center: (Manhattan)

- Mondays 10:00 AM - 1:00 PM
- Tuesdays 10:00 AM - 1:00 PM

Memorial Sloan Kettering Cancer Center: (Manhattan)

- Tuesdays 1:00 PM - 3:00 PM
- Tuesdays 3:00 PM - 5:00 PM

Stony Brook University Hospital: (Suffolk)

- Wednesdays 1:00 PM - 3:00 PM
- Wednesdays 3:00 PM - 6:00 PM

Maimonides Medical Center: (Brooklyn)

- Wednesdays 10:00 AM - 2:00 PM

Cohen Children's Medical Center: (Queens)

- Tuesdays 9:30 AM - 12:00 PM
- Tuesdays 12:00 PM - 2:30 PM
- Tuesdays 2:30 PM - 4:30 PM
- Wednesdays 9:30 AM - 12:00 PM
- Wednesdays 12:00 PM - 2:30 PM
- Fridays 9:30 AM - 12:00 PM
- Fridays 12:00 PM - 2:30 PM

New York Presbyterian/Columbia: (Manhattan)

- Tuesdays 10:00 AM - 1:00 PM

Maria Fareri Children's Hospital: (Westchester)

- Thursdays 9:00 AM - 12:00 PM
- Tuesdays 11:00 AM-2:00 PM

Hackensack University Medical Center: (NJ)

- Wednesdays 10:00 AM - 1:00 PM

## References

Please list 2 personal references (other than relatives) that we may contact who have knowledge of your character, experience and ability. Also, include 2 current or past employer references.

### Personal References:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Length of time known: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Length of time known: \_\_\_\_\_

### Professional References:

Name: \_\_\_\_\_ Length of time known: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Position: \_\_\_\_\_

Name: \_\_\_\_\_ Length of time known: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Position: \_\_\_\_\_

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

## AUTHORIZATION TO CHECK CRIMINAL RECORDS

I, \_\_\_\_\_, hereby authorize the Sunrise Association and/or Sunrise on Wheels to obtain information pertaining to any charges I may have for federal and state criminal law violations. This information will include convictions committed upon minors and adults, and will be gathered from any law enforcement agency of this state or any other state or federal government to the full extent permitted by law.

I understand that such access is for the purpose of considering my application as a volunteer and that I expressly DO NOT authorize the Association, its directors, officers, employees, or other volunteers to disseminate this information in any way to any other individual, group, agency, organization or corporation.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Signature of Applicant)

### PLEASE RETURN APPLICATION TO:

**Dulcie Auerfeld**  
Senior Coordinator, Sunrise on Wheels  
15 Neil Court, Oceanside, NY 11572  
Phone: 516-634-4017 • fax: 516-705-0490  
Email: [dauerfeld@FriedbergJCC.org](mailto:dauerfeld@FriedbergJCC.org)

• *In New Jersey or Westchester, please contact:*

**Lisa Lehrman**  
Hospital Liaison, Coordinator of Sunrise on Wheels  
Sunrise Day Camp - Pearl River  
15 Neil Court, Oceanside, NY 11572  
Phone: 516-634-4017  
Email: [lisa.lehrman@sunriseassociation.org](mailto:lisa.lehrman@sunriseassociation.org)