



ASIAN PACIFIC HEALTH CARE VENTURE, INC. VOLUNTEER/INTERN APPLICATION

Mail completed application to: Asian Pacific Health Care Venture
Attn: Administrative Manager
1530 Hillhurst Avenue, Suite 200
Los Angeles, CA 90027

Please include a resume of your previous work experience, paid and volunteer.

PLEASE TYPE OR PRINT CLEARLY

Last Name		First	M.I.	Date
Street Address		City	State	Zip Code
Home Phone ()		Work Phone ()		
Do you have access to a car? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		Can we call you at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
Occupation			Number of hours/week	
Best time & place to be reached				Social Security No.

IN CASE OF EMERGENCY:

Person to contact	Relationship to you
Address	Phone Number ()

DATES AVAILABLE		Starting: _____ Ending: _____					
DAY OF WEEK	M	T	W	R	F	Sa	Su
HOURS YOU ARE AVAILABLE							

EDUCATION	SCHOOL NAME	MAJOR	DEGREE	HAVE YOU GRADUATED?
High School				<input type="checkbox"/> Yes <input type="checkbox"/> No
College				<input type="checkbox"/> Yes <input type="checkbox"/> No
Post Grad				<input type="checkbox"/> Yes <input type="checkbox"/> No
Trade School				<input type="checkbox"/> Yes <input type="checkbox"/> No

SKILLS/EXPERIENCE/HOBBIES/SPECIAL TALENTS:

- Computers
- Typing WPM: _____
- Research
- Writing
- Fund raising
- Teaching
- Public Speaking
- Translation
- OTHER: _____

LANGUAGES:

Spoken: _____ Written: _____ Read: _____

➤ DO YOU HOLD A LICENSE/CERTIFICATION IN ANY OCCUPATIONAL FIELD?

- Yes No If yes, please attach copy

If yes, what type? _____ Lic. #: _____

Type: _____ Lic. #: _____

➤ HOW DID YOU HEAR ABOUT APHCV'S VOLUNTEER PROGRAM?

- Friend/Relative
- Flyer
- OTHER: _____
- Teacher
- Magazine/Newspaper

➤ IN WHICH AREA(S) ARE YOU INTERESTED?

Please number your top three choices (1 for 1st choice, 2 for 2nd choice, etc.)

☒ HEALTH EDUCATION

_____ HIV/AIDS Programs

_____ Tobacco Education

_____ Youth Programs

_____ TB

_____ Outreach

☒ CLINIC

_____ General

_____ Patient Care

☒ PATIENT SUPPORT SERVICE

_____ Interpretation

_____ Material Development/Translation

_____ Patient Education Classes

_____ Reference/Information Organization

_____ Outreach

☒ HEALTH EDUCATION

_____ Clerical Support

If you are under 18, a parent/guardian's signature is required.

Parent/guardian Signature

Date

I hereby certify that I have not knowingly withheld any information that might adversely affect my chances for an internship or volunteer work and that the answers given by me are true and correct to the best of my knowledge. I further certify that I, the undersigned applicant, have personally completed this application. I understand that any omission or misstatement of material fact on this application or on any document used to secure placement shall be grounds for rejection of this application or for immediate discharge, regardless of the time elapsed before recovery.

Applicant's Signature

Date

