



CITY OF VISTA
APPLICATION FOR VOLUNTEER SERVICE

DATE _____

1. NAME _____ ARE YOU AT LEAST 18 YRS. OLD? _____

2. RESIDENCE ADDRESS _____ CITY _____ ZIP _____

3. BUSINESS ADDRESS _____ CITY _____ ZIP _____

4. HOME PHONE _____ BUSINESS PHONE _____

5. EDUCATION: LIST HIGHEST GRADE ATTAINED; DEGREES, IF ANY; SCHOOLS; TRAINING:

6. HAVE YOU EVER BEEN CONVICTED OF A FELONY? YES___ NO___
IF YES, PLEASE EXPLAIN OFFENSE(S) FOR WHICH CONVICTED: _____

7. LIST THE SPECIFIC ACTIVITY OR INTEREST AREA YOU WOULD LIKE TO WORK IN:

8. EXPLAIN WHY YOU ARE INTERESTED AND WHAT ABILITIES AND/OR EXPERIENCE YOU HAVE IN THIS AREA:

9. CIRCLE DAYS AVAILABLE FOR WORK: M TU W TH F SA SU

TIME/HOURS AVAILABLE TO WORK: _____

10. REFERENCES: INCLUDE AT LEAST TWO INDIVIDUALS WHO ARE NOT CONNECTED OFFICIALLY WITH THE CITY OF VISTA. PLEASE GIVE NAME AND PHONE NUMBER.

11. ARE YOU CURRENTLY AN EMPLOYEE OF THE CITY OF VISTA? YES___ NO___

SIGNATURE OF APPLICANT

SIGNATURE OF PARENT (if applicant is under 18 years)

APPROVED

DATE



**City of Vista
Recreation & Community Services Department**

I, _____, agree and understand that any work that I may perform on behalf of the Recreation and Community Services Department will be provided on a voluntary basis, and that I do not expect payment or other compensation for performing such work. I am aware that the City liability insurance includes coverage for injuries occurring to me while volunteering for the City of Vista. I have been advised that this insurance is in excess of any other medical insurance I may have. I further understand and agree that a volunteer position does not constitute an employee-employer relationship with the City of Vista, and that the City may terminate my volunteer status at anytime without cause, advance notice or right of appeal.

THANK YOU FOR VOLUNTEERING WITH THE CITY OF VISTA!

Effective May 24, 2005, all volunteers are covered under the City's Workers' Compensation Insurance.

If you are injured while volunteering, please go to:

TRI-CITY MEDICAL PLAZA

2095 West Vista Way, Suite 106

Vista, CA 92083-6028

Office / Oficina: (760) 940-3590

Fax: (760) 940-7261

Hours: Monday-Friday, 8:00 a.m. – 5:00 p.m.

TRI-CITY MEDICAL CENTER

EMERGENCY DEPARTMENT

DEPARTAMENTO DE EMERGENCIA

4002 Vista Way

Oceanside, CA 92056

(760) 940-3517

After Hours Emergency Room