boomerang HEALTH | POWERED BY SickKids

Volunteer and Learner Request Form

OFFICE USE ONLY
Date application received _____
Applicant Placed ☐ Yes ☐ No
Preceptor _____
Start Date _____
Signature _____

First Name _____ Last Name _____
Address _____
Email _____
Telephone (Home) _____ Telephone (Cell) _____
Emergency Contact Name _____ Relationship _____
Telephone (Home) _____ Telephone (Cell) _____

Type of Request

- ☐ Student affiliated with an academic institution (e.g. completing a placement)
- ☐ Medical Resident
- ☐ Medical Fellow
- ☐ Volunteer (minimum of 3 months commitment)
- ☐ Clinical Observer (i.e. observation in patient care)

Please fill out the following academic information, if applicable:

Educational Institution _____
Program of Study _____
Degree/Diploma _____
Year of Study _____ Expected Date of Completion _____
Academic Contact _____
Telephone _____ Email _____

Experience Start Date _____ Experience End Date _____
Number of Hours Required _____

Days of the week you are available for the experience

Days	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Times (indicate the times that you are available on each day)							

What are your learning objectives/goals and interests?

What are your relevant experiences related to this request?

Once completed, please **email this form and your resume** to info@boomeranghealth.com.
Please indicate in the subject heading the **type of experience** that you are seeking.