UAMS
VOLUNTEER

Volunteer Services

Needs Assessment Form

Please complete and return to slot 527 or legray@uams.edu

Name of Department: _____

Location of Department: _____ **Slot #:** _____

Contact Person: _____ **Phone #:** _____

Description of Department (Type of patients served, services rendered, etc.):

Qualifications/Education/Skills Necessary for Volunteer:

_____

Days/Times Needed (Check all that apply):

___ Monday ___ Tuesday ___ Wednesday ___ Thursday ___ Friday ___ Weekends

___ Morning ___ Afternoon ___ Evenings Specific Peak Times: _____

Number of Volunteers Needed: _____ **Is this an ongoing volunteer opportunity?** _____

Description of Duties (Please list all duties for which volunteers will be responsible):

_____

_____

_____

This position is (check one): ___ Urgent ___ Important ___ Helpful ___ Not a High Priority

Signed: _____ **Date:** _____

_____

FOR OFFICE USE ONLY:

Received: _____ Processed: _____ By: _____

Date: _____ Service Description: _____