

# Adult Volunteer Recommendation Form

We welcome applicants of any race, color, sex, age, religion, creed, disability, ancestry or national origin.

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Applicant's First Name	Applicant's Last Name	Date
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This applicant has expressed her/his desire to volunteer at The Christ Hospital. We would appreciate your opinion of the individual's suitability to perform the services of a hospital volunteer. The following qualities in a volunteer contribute to the success of our program.

**Please check the appropriate box**

	<b>1</b> Poor	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b> Very Good
Dependability	1	2	3	4	5
Mental/Physical Alertness	1	2	3	4	5
Punctuality	1	2	3	4	5
Accuracy of Work	1	2	3	4	5
Positive Judgment	1	2	3	4	5

How long have you known this applicant?

Would you recommend this person to volunteer? Please explain.

What are the applicants strengths and weaknesses?

Please feel free to add any additional comments.

Signature: \_\_\_\_\_ (  ) Teacher (  ) Friend (  ) Other

**You may return this form directly to**  
**The Christ Hospital Volunteer Services Department**  
**2139 Auburn Ave**  
**Cincinnati, OH 45219**  
 Or  
[volunteer@thechristhospital.com](mailto:volunteer@thechristhospital.com) (preferred)