

APPLICATION FOR NON-PAID OPPORTUNITY

PLEASE CHECK ONLY ONE:

☐ Volunteer ☐ Visiting Resident ☐ Visiting Scholar/Student ☐ Post Doctoral Fellow
☐ Contract (Pre-Approved by HR to be Paid by Accounts Payable)

1. Name: _____ 2. SSN: _____ - _____ - _____
3. Address: _____ Apt #: _____
City: _____ State: _____ Zip: _____
4. Phone No.: (____) - ____ - _____ 5. E-Mail: _____
6. Date of Birth: ____ / ____ / ____* 7. Relatives Employed at MUSC? ____Y ____ N
* If Age 16 or under, please attach parental permission If Yes list Name/Relationship/Dept: _____
8. Gender: ____M ____F 9. Salutation: ____ Ms. ____ Mr. ____ Dr.
10. Education (Last year of school completed):
Name of School: _____ City/State: _____
Did you Graduate? ____ No ____ Yes Degree/Major: _____
11. Current/Most Recent Occupation/Employer: _____
Dates of Employment: Start ____ / ____ End ____ / ____
12. Special Skills/Talents: _____
13. Area(s) of Interest: ____ Research ____ Lab ____ Administrative ____ Data Entry
____ Supply Svcs ____ Human Resources ____ Other: _____
____ Observation Only: Dept/Area: _____
14. What are your days/hours of availability to work/observe? _____
15. What is the approximate length of time you expect to serve in this role? _____
16. Have you ever been convicted of any crime other than a traffic violation? ____ Yes ____ No If yes, please explain:

17. Please indicate the date(s)/time(s) that you are **guaranteed** to be available for a health screening:

I understand that the Medical University of South Carolina reserves the right to accept or reject my application in its sole discretion and that the above statements made in this application are true and correct. I authorize the Medical University of South Carolina to conduct a criminal record search to verify my suitability for this opportunity. I understand and willingly agree to perform in the above-referenced opportunity with no compensation. I understand that should I become ill or injured while performing in this capacity, I will NOT be covered by MUSC's Worker's Compensation. I understand that it will be necessary to obtain any required medical attention from my family physician, and I release and hold MUSC harmless from any implied liability.

Signature: _____ Date: _____