

CONFIDENTIAL - TEEN VOLUNTEER SERVICES APPLICATION

For Internal Use: Certifications _____ Community Service _____ _____

Personal Information

First _____ Middle _____ Last _____

Parent or Guardian Name _____

Date of Birth _____ Social Security # _____

Driver's License # _____ Photo Copy [] Yes [] No

Address _____

City _____ State _____ Zip _____

Phone # _____ Secondary Phone # _____

E-mail address _____

.....

Emergency Information

Emergency Contact Name _____

Relationship to you _____ Home Phone # _____

Work Phone # _____ Secondary Phone # _____

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Education/Community Involvement/Work Experience

Name of School _____ Grade: _____

Courses current taking, school activities, clubs, honors, etc.

Do you have plans to continue your education after high school? [] Yes [] No

If yes, what course of study do you want to pursue? _____

What career (job) do you hope to pursue as an adult? _____

List any community affiliations (church, civic groups, etc.) _____

Are you seeking volunteer opportunities as a requirement for any of the above activities or groups? Yes No If yes, please explain _____

Have you ever volunteered in the past (school, civic)? Yes No If yes, please explain _____

Questionnaire

1. Is there anything that may adversely affect your ability to perform volunteer work?

Yes No If yes, please describe in detail: _____

2. Are there any accommodations needed in order for you to safely and competently perform volunteer work as requested? _____

3. Do you have any physical, visual or hearing needs we need to consider?

Yes No If yes, please describe in detail: _____

4. Are you physically able to transport patients? Yes No

5. Why are you interested in volunteering? _____

6. How did you hear about our Teen Volunteer Program? _____

7. When can you start volunteering? _____

8. Special interests/hobbies/skills: _____

9. Do you have any friends, relatives, acquaintances employed by or volunteering at this hospital? Yes No If yes, please list

Name	Position	Relationship
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10. Check when you wish to volunteer. Each shift is 4 hours.

[] Monday _____ to _____

[] Tuesday _____ to _____

[] Wednesday _____ to _____

[] Thursday _____ to _____

[] Friday _____ to _____

[] Saturday _____ to _____

[] Sunday _____ to _____

11. Please check all areas that you are interested in volunteering in this hospital.

- Information Desk
- Gift Shop
- Nursing Services (ICU, ER, Med/Surg, OB, Surgery)
- Ancillary Services (Lab, Pharmacy, Radiology, Rehab, Respiratory)
- Facility Services (Maintenance, Housekeeping, Dietary)
- Support Services (Accounting, Business Office, Human Resources, Patient Access, Marketing, Material Management)

12. Special Skills/Interests

Check the items, in which you have abilities or experience.

A. Technical _____

Typing _____

Filing _____

Computer Operations _____

Audio Visual _____

B. Creative _____

Sewing _____

Needlework _____

Musical Instruments _____

Photography _____

Art Work _____

Gardening _____

Calligraphy _____

Crafts _____

C. Other skills please list

Briefly explain why you want to join our Teen Volunteer Program:

References

(NOTE: A letter of recommendation from one of your listed references must be included with this application). Please include references for any current or former job supervisors, teachers or clergy. Family members, relatives and friends may not be considered references.

1. Name _____ Phone #: _____

Relationship to you _____ Business Name _____

Address: _____ City _____ State _____ Zip _____

2. Name _____ Phone #: _____

Relationship to you _____ Business Name _____

Address: _____ City _____ State _____ Zip _____

3. Name _____ Phone #: _____

Relationship to you _____ Business Name _____

Address: _____ City _____ State _____ Zip _____

APPLICANT SIGNATURE

I hereby completed this application for the Teen Volunteer Program. I agree to a drug test for participation in this program. I understand that the Volunteer Services Director makes all regular assignments, based on a personal interview and evaluation of each prospective teen volunteer. I agree to abide by the policies and procedures of the Volunteer Services Department.

Teen's Signature _____

Date _____

PARENT/GUARDIAN SIGNATURE

I hereby permit by son/daughter/charge _____ to participate in the Teen Volunteer Program. I also give permission for a drug test to be completed on my son/daughter/charge for participation in this program. I further release this Hospital from any legal or other responsibilities for any injuries, act or incidents involving the volunteer.

Parent/Guardian Signature _____ Date _____

Home Phone #: _____ Work Phone # _____

