Springhill Medical Center
Teenage Volunteer Application

Office Use Only:

Received Application: _____ **Parent/Teen Meeting:** _____

Service Area Discussed: _____

Drug Test: ___ **Immunization Record:** ___ **Health Assessment:** ___

Background Check: ___ **Confidentiality:** ___ **Attestation:** ___

Name: _____

Address: _____

City/State/Zip: _____

Home Telephone: _____ Parent's/Guardian's Work Phone:_____

Cell Phone:_____ *E-mail address: _____

Birth date:_____ Social Security Number:_____

School:_____ Grade:_____

Grade Point Average:_____ Year Will Graduate:_____

Please provide an email that is regularly monitored as we primarily use this form of communication

Information for Service Area Placement:

- Have you ever volunteered in a hospital _____Yes _____No
- Have you ever volunteered on a committee? _____Yes _____No
- Would you be willing to work on special projects? _____Yes _____No
- Are you available to work at least one four-hour shift per week? _____Yes _____No
- Are you available to substitute on other days? _____Yes _____No
- Do you have work experience operating?
  Cash Register_____ Computer_____

List any clubs, sports, or organizations to which you belong:

_____

Will any of these club activities interfere with your volunteer work? _____ If so, how?

_____

_____

Why do you wish to volunteer at Springhill Medical Center?

_____

_____

_____

If accepted as a Springhill Medical Center teenage volunteer, I

- ***agree to attend orientation*** and train until I am competent to perform the required duties.
- understand that I may be dismissed from my duties for willful wrongdoing and negligence and/or performing duties outside my service guidelines.
- agree to report for duty on time, and notify the Director of Volunteer Services A.S.A.P., preferably in advance, when I am unable to report on my scheduled day.
- agree to keep medical, financial and personal information confidential.
- will perform my volunteer duties in a professional manner, and will be a good representative for Springhill Medical Center.

I have read and understand the statements above, and agree to abide by the expectations of Springhill Medical Center.

Applicant's Signature:_____

Please have your parent or legal guardian complete the Information below and sign the application.

Mother's/Guardian's Name: _____ Occupation:_____

Business Address: _____ Business Telephone: _____

Father's/Guardian's Name: _____Occupation: _____

Business Address: _____ Business Telephone: _____

Person to notify in case of emergency: _____

Home Phone: _____ Business Phone: _____

Cell Phone: _____

Parent's/Guardian's Consent/Permission:
I hereby give my permission for _____
to volunteer at Springhill Medical Center. I understand that no wages of any kind will be received for services performed by my child. I also agree to purchase the required uniform (Available from hospital) for my child. I will support my child's efforts by accompanying him/her to the parent/teen meeting, and will make sure that he/she abides by all hospital policies and reports for duty on time in a clean pressed uniform.

Parent's/Legal Guardian's Signature: _____

Date:_____

A recommendation from a school counselor or teacher is required. Your application will not be considered until this recommendation has been received. Please use the space provided below to obtain your recommendation and return it with your **application by March 28th** to

Cindy McFadden
Volunteer Services
Springhill Medical Center
3719 Dauphin Street
Mobile, AL 36608

Student Counselor/Teacher Recommendation

Student Name: _____

Do you feel that this student would be a good volunteer for Springhill Medical Center?

Yes_____ No_____

Counselor/Teacher Signature: _____

Title: _____

Telephone: _____

Date: _____