APPLICATION FOR TEEN VOLUNTEER

Name:____ **Date:**______________

Home Address:__________________________ **City**_______________ **State**_____ **Zip Code**__________

Date of Birth:________________________**Home Phone:**________________**E-mail**______________

Parent or Guardian's Name:____

Address:____

Name of School:____

Address of School:____

Interests and Hobbies:____

Volunteer Experience:____

Type of Volunteer Work Preferred:____

Why?____

Who referred you to this Hospital?____

Please list day(s) and time(s) you would like to Volunteer. ___________________________________

PERSON TO BE CONTACTED IN AN EMERGENCY:

Name:______________________________ **Relationship:**________________________

Address:________________________ **City & State**______________ **Phone #** ____________________

Career Planned:____

Why do you want to be a Volunteer at Trinitas Hospital?

____

____

References: **1.** ____
Name **Relationship to you** **Phone No.**

2. ____
Name **Relationship to you** **Phone No.**

Please read the following carefully before signing this application

I understand that this is an application for and not a commitment or promise of volunteer opportunity.

I certify that I have and will provide information throughout the selection process, including on this application for a volunteer position and in interviews with Trinitas Hospital that is true, correct and complete to the best of my knowledge. I certify that I have and will answer all questions to the best of my ability and that I have not and will not withhold any information that would unfavorably affect my application for a volunteer position. I understand that misrepresentations or omissions may be cause for my immediate rejection as an applicant for a volunteer position with Trinitas Hospital or my termination as a volunteer. I hereby authorize that I may be interviewed, photographed or videotaped by a photographer or videographer authorized by Trinitas Hospital. I understand that such interview, photograph or video may be used in print and electronic communications. I further understand that this consent is expressly intended to release all personnel of Trinitas Hospital, as well as the attending physician and consultants, from any claim arising out of the use of such interviews, photographs and/or videotape

____

Signature **Date**

Dear Parent or Guardian:

PLEASE READ THE FOLLOWING CAREFULLY

Your son/daughter has expressed an interest in becoming a Volunteer at Trinitas Hospital. We would be very happy to accept him/her as a member of the Trinitas Teen Volunteer Program, if this meets with your approval.
We would appreciate it if you would sign the consent form below and have your son/daughter return it to us as soon as possible since it becomes part of their permanent record.
The form assures Trinitas Hospital that:

1. **Your son/daughter is 14 years of age or older.**
2. **He/she volunteers with your approval.**
3. **Both you and he/she realize that volunteering is now his/her responsibility and should be taken very seriously. He/she agrees to complete a minimum of 50 volunteer hours. He/she must follow all rules and regulations established and be regular in attendance. We will be depending on him/her to be here on the days on which he/she is registered. Should a volunteer be negligent of his/her duties, it may be cause for dismissal from the program.**
4. **He/she is not to be at the Hospital on any other days or times than those assigned except when visiting a patient.**
5. **He/she is at the Hospital as part of our Volunteer Program. Excessive socializing on the premises may result in termination.**
6. **It is the duty of the parent/guardian to assume responsibility for transportation to and from the Hospital.**
7. **Unless there is an emergency, Volunteers may not make or receive phone calls. Please arrange transportation ahead of time.**
8. **Uniforms are required. A $15 deposit is required which will be returned when the volunteer no longer participates in our Volunteer Program. Uniforms must be worn at all times and it is the responsibility of the Volunteer to keep their uniform neat and clean.**

Director - Volunteer Services
Trinitas Hospital

TO: DIRECTOR OF VOLUNTEER SERVICES

My son/daughter ____________________ is 14 years of age or older and has my consent to do Volunteer work at Trinitas Hospital on the day/days for which he/she is scheduled and to adhere to the rules and regulations of the Volunteer Program.

____

Signature **Date**

Please check one: Parent____________________ Guardian____________________

VOLUNTEER SERVICES DEPARTMENT

THIS HEALTH CERTIFICATE MUST BE COMPLETED BY A PHYSICIAN BEFORE APPLICANT MAY VOLUNTEER AT TRINITAS HOSPITAL.

VOLUNTEER APPLICANT:____

ADDRESS:____

1. TO MY KNOWLEDGE THIS APPLICANT:

IS FREE FROM CONTAGIOUS DISEASE AND CAPABLE OF PERFORMING VOLUNTEER ASSIGNMENTS AT TRINITAS HOSPITAL.

YES__________ **NO**__________

2. HAS THE FOLLOWING PHYSICAL AND/OR EMOTIONAL CONDITION REQUIRING RESTRICTIONS AND/OR PRECAUTIONS TO BE OBSERVED:

PLEASE NOTE RESTRICTIONS AND/OR PRECAUTION:

____

____

____

HAS NO RESTRICTIONS:

_____________________________ _____________________________

PHYSICIAN'S NAME (PLEASE PRINT) **PHYSICIAN'S SIGNATURE**

_____________________________ _____________________________

PHYSICIAN'S ADDRESS **DATE**

PLEASE RETURN COMPLETED FORM TO THE VOLUNTEER SERVICES DEPARTMENT.

To the Guidance Counselor:

Mr./Miss ________________________ has expressed an interest in becoming a Teen Volunteer at Trinitas Hospital.

In order to insure the selection of the most eligible applicants, we would appreciate your cooperation by completing the following questionnaire. If you have any questions, please feel free to contact Lisa Liss, Director of Volunteer Services at (908) 994-5164.

Thank you for your assistance.

1. **Scholastically, the applicant is considered:**

   Excellent______ Good______ Fair______

2. **The applicant is cooperative and accepting of authority:**

   Excellent______ Good______ Fair______

3. **The applicant is conscientious:**

   Excellent______ Good______ Fair______

4. **The applicant is willing and able to follow directions:**

   Excellent______ Good______ Fair______

5. **The applicant's attendance and tardy record is:**

   Excellent______ Good______ Fair______

6. **The applicant is in good health:**

   Excellent______ Good______ Fair______

I recommend the applicant as a Teen Volunteer:

With enthusiasm______ For a trial period______ I would not recommend______

____ ________________

Signature Date

____

School

TRINITAS HOSPITAL

Dear Parent or Guardian:

Your permission is necessary for ______________________________ to have a two–step Mantoux Test for TB. If the Mantoux Test for TB is positive, it will be necessary to have a chest x-ray performed. If positive, a urine test for pregnancy will be required for all females. Please sign below to indicate your approval.

PLEASE SUBMIT A COPY OF YOUR CHILD'S IMMUNIZATION RECORD ALONG WITH THIS APPLICATION. THIS CAN BE OBTAINED FROM YOUR CHILD'S PHYSICIAN OR SCHOOL NURSE.

Sincerely,

Lisa E. Liss
Director - Volunteer Services

I give permission to the staff of Trinitas Hospital to complete all hospital requirements for pre-placement tests.

______________________________ **_______________**
Parent or Guardian Signature **Date**

____
Relationship

rev.11/19/08

DO NOT WRITE ON THIS PAGE

TO BE COMPLETED BY VOLUNTEER OFFICE:

INTERVIEW DATE:______________________________

ORIENTATION DATE:____________________________

STARTING DATE:____________________ **PRECEPTOR:**________________________

VOLUNTEER ASSIGNMENT:____

DAY:___________________ **TIME:**___________________

PHYSICAL LIMITATIONS:____

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REMARKS:____

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