CAMP INDEPENDENCE
WINTER 2012

Volunteer Application

Personal Information

Please print using black or blue ink.

Circle one: Mr./Ms./Mrs./Dr. Today's Date: _____

Last Name: _____ First Name: _____ MI _____

Current Address

Street: _____

City: _____ State: _____ ZIP: _____

Permanent address (if different from current)

Street: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-Mail Address: _____

☐ High School ☐ College ☐ Graduate School ☐ Adult

In case of an emergency, notify: _____ Relationship: _____ Phone: _____

Volunteers under age 18 must list a parent or legal guardian as emergency contact.

Educational History

High School or Program: _____ Present Grade: _____

High School Completed: ☐ Yes ☐ No

College: _____ Major: _____ ☐ Undergraduate ☐ Graduate

☐ BS/BA ☐ MS/MA ☐ Ph.D. ☐ Other_____

Employment

Present (or most recent) Employer

Company Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone number: _____ Fax number: _____

Position: _____ Dates of Employment: _____

Have you ever been employed by St. Louis Children's Hospital? ☐ no ☐ yes (If yes, please specify)

Department: _____ Manager/Supervisor: _____

Dates of employment (MM/YY): from _____ to _____

(over)

Volunteer Information

I am applying for 2012 Winter Camp Independence:

☐ December 27 ☐ December 28

School Service Coordinator: _____ Day time phone #: _____

Which days of the week are you available to volunteer? **(Please check all that apply)**

☐ Thursday ☐ Friday

Do you prefer to volunteer (check one) in the:

☐ All Day (Preferred) ☐ Morning (10:00 – 12:00), ☐ Afternoon (1:00 – 4:00)

I would like to volunteer for the Hatfield Cerebral Sports & Rehabilitation Center at St. Louis Children's Hospital because: _____

_____

If you could create for yourself the perfect volunteer experience, what would it be? _____

_____

How did you hear about us? ☐ Internet ☐ Newspaper ☐ Employee ☐ Other: _____

References

It is mandatory that all applicants provide two references that are current and professional in nature.

Enclosed are two reference forms. Please fill in your name and give them to two people you wish to use as a reference. References can not be a relative, or individual with whom you reside, and must be 19 years or older. High School students should use at least one teacher, counselor or coach as a reference. Please ask your references to complete the form and return it to us promptly.

For our records, please complete the section below. Please provide complete addresses.

Reference One:

Name: _____ Relationship:_____

Business/School Name: _____ Phone: _____

Address: _____ City: _____ State: _____ ZIP: _____

Reference Two:

Name: _____ Relationship**:** _____

Business/School Name: _____ Phone: _____

Address: _____ City: _____ State: _____ ZIP: _____

Immunization History

Immunization Record: Students (High School and College) **MUST** provide a copy of immunization records from a health care provider. Please include these records with your application.

Have you ever had:	Unknown	No	Yes	Date	Immunization/Date
Chicken Pox	☐	☐	☐	_____	☐ _____
Hepatitis	☐	☐	☐	_____	☐ _____
Measles	☐	☐	☐	_____	☐ _____
Mumps	☐	☐	☐	_____	☐ _____
Rubella	☐	☐	☐	_____	☐ _____
Polio	☐	☐	☐	_____	☐ _____

Tuberculosis Skin Test Guidelines: All volunteers are required to have a TB test within the last 12 months.

- If you have had a TB test in the past 12 months, enclose a copy of the test results.
- If you have not had a TB test in the past 12 months, a test can be done free of charge at the hospital.
- Tests are repeated annually.

By signing this application, I agree to the following:

- I release from all liability or responsibility all persons or organizations requesting or supplying information regarding my character and qualifications.
- I understand that I may come in contact with information that is confidential in nature.
- I understand the sensitive nature of health care information and I agree to protect the privacy and confidentiality of patients and families.
- I will provide complete reference information, documentation of immunizations, and TB test results.
- I have provided information, which is true and complete to the best of my knowledge.
- If I have provided false information, I may not be allowed to volunteer or I may be dismissed in the future.
- I understand that any misuse of information is grounds for termination of my volunteer service without prior notice.

Signature of Applicant: _____ Date: _____

For applicants under 18 years of age:
Parental/Guardian Permission (required for applicants under 18 years of age).

I give my child _____ permission to volunteer at St. Louis Children's Hospital and I agree to the following statements,

- I understand that my child may obtain a record of hours volunteered.
- I will provide a copy of the test results if my child has had a tuberculosis skin test within the last year.
- I give permission for my child to receive a TB test at St. Louis Children's Hospital if a record can not be produced.
- I understand that my child is required to have a TB test before he/she can begin volunteering.
- As long as my child is a volunteer at St. Louis Children's Hospital, I agree that my child may have annual TB testing performed by the Hospital.

Signature of Parent or Guardian: _____ **Date:** _____

Please review the Volunteer Application carefully before submitting it. Any missing or incomplete information can delay processing of your application.

Contact Information:

St. Louis Children's Hospital
Hatfield Cerebral Palsy Sports and Rehabilitation Center
One Children's Place, Room 11E18
bam8581@bjc.org
St. Louis, MO 63110
Phone: (314) 454-2642 Fax: (314) 454-2492

ID Badge Form/Background Check

Please print.

First Name: _____ Middle Name: _____ Last Name: _____

Date of Birth (MM/DD/YY) _____ Sex: _____ Social Security No._____

The above information is required for all volunteers.

Volunteers age 18 and over - A background check is required on all applicants over 18 years of age. To do a background check, we must have your permanent address and your prior addresses from the past five years.

Permanent Address

Street: _____

City: _____ State: _____ ZIP: _____

Address for the Past Five Years

Street: _____ Street: _____

City: _____ State: _____ ZIP: _____ City: _____ State: _____ ZIP: _____

Other than minor traffic offenses in which the fine imposed was $100 or less, have you ever:

- Been convicted of a crime (misdemeanor or felony)?
- Received a probated sentence (including deferred adjudication) for an alleged crime?
- Been assigned a probation officer?
- Plead guilty, no contest, or nolo contendere to an alleged crime?
- Been made the subject of a complaint or investigation concerning alleged child or elder abuse or neglect?
- Been listed on the employee disqualification list maintained by the Missouri Division of Social Services, or any other state?

☐ No ☐ Yes If the answer is **YES**, specify the offense, date, place, and court which has a record thereof.

_____

_____

By signing this form, I agree to the following:

- I authorize the release of any criminal history records and information to St. Louis Children's Hospital.
- I understand that my volunteer assignment is contingent upon a clean background check.
- I understand that St. Louis Children's Hospital will conduct a child abuse screening on me through the Division of Family Services and a criminal background check.
- I release from all liability or responsibility all persons or organizations requesting or supplying information regarding my character and qualifications.
- I have provided information, which is true and complete to the best of my knowledge.
- If I have provided false information, I may not be allowed to volunteer or I may be dismissed in the future.

Signature of Applicant: _____ Date: _____

For office use only:

☐ OIG ☐ One Screen Date Started: _____

☐ DFS ☐ EDL ☐ _____ Date Completed: _____

CAMP INDEPENDENCE

St. Louis Children's Hospital
Volunteer Reference

Please complete the following information and return it to:
St. Louis Children's Hospital
Hatfield Cerebral Palsy & Sports Rehabilitation Center
One Children's Place, Room 4S50
St. Louis, MO 63110
(314) 454-2642

Applicant's Name: _____
Address: _____
City, State, ZIP: _____
Phone Number: _____

_____ has applied to volunteer at St. Louis Children's Hospital. Your reference is important in helping us decide whether to accept this applicant as a volunteer. Please take a few minutes to tell us how you perceive the candidate in each of the following categories and return the form to the above address at your earliest convenience. Thank you for your help.

Please indicate with a checkmark below the candidate's ability to:

Category	Excellent	Very Good	Average	Fair	Poor	N/A
Work with children						
Fulfill commitments and responsibilities						
Maintain confidentiality						
Exhibit emotional maturity						
Communicate verbally						
Take initiative						
Be courteous and polite to others						
Work as a member of a team						
Accept redirection or constructive criticism						
Follow instructions						
Work independently						
Perform tasks						
Understand and adhere to organizational structure, policies and procedures						
Manage stressful situations						
Be flexible/adaptable to change						
Be prompt						

Comments (may continue on back)_____

_____

How long have you known the applicant? _____

How do you know the applicant?_____

Name (please print) _____

Signature _____

Daytime Phone Number ( ) _____ Date _____

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St. Louis Children's Hospital
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St. Louis, MO 63110
(314) 454-2642

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Comments (may continue on back) _____

_____

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How do you know the applicant? _____

Name (please print) _____

Signature _____

Daytime Phone Number ( ) _____ Date _____

Children's HOSPITAL • ST. LOUIS
BJC HealthCare™

Volunteer Application Checklist

Please use this checklist to ensure your application is complete.

☐ **Please print, using either black or blue ink**.
Please do not use pencil.

☐ **List Emergency contact.**
Are you under the age of 18? If yes, you must list a parent or legal guardian as your emergency contact. Please list their first and last name, relationship and phone.

☐ **Fill out the reference section completely.**
All applicants must have two references. The completed reference forms can either be submitted with your application, or your reference can mail the completed form separately. We will begin to process your application when both references are received.

Give the forms to the two people you listed on the application. The completed form must be returned. Applicants can *not* use a parent, other relative, or individual with whom you reside as a reference.

☐ **Complete the immunization section.**
High School and College Students must provide a copy of immunization records from a health care provider with their application. Please do not have your health care provider fax it separately. Adults should provide the dates of the immunization or the disease itself.

☐ **Sign and date the application.**
If you are under 18 years of age, your parent or guardian must also sign and date the application.

☐ **Complete the ID Badge Form/Background Check page.**
All applicants regardless of age must complete the top portion of the application. Our Security Department requires this information in order to provide a Volunteer ID Badge. Applicants over the age of 18 must complete the entire form. If you are a college student, please use your home address as your permanent address.

☐ **Mail your application!**
Please mail to the Contact Information address at the bottom of page 3.

Questions? Call us at 314-454-2642 or e-mail at mbe2187@bjc.org.