For Internal Use:
Birth Date _____
SS # _____
Drug Test _____
Background _____

SUMMER SCRUBS

JUNIOR VOLUNTEER PROGRAM APPLICATION (AGES 14 – 18)

Thank you for your interest in becoming a Teen Volunteer. Please return your application, signed by you and your parent or guardian, **along with a letter of recommendation from a teacher** to the Volunteer Services Department. A drug test is a mandatory requirement before volunteer placement can begin. Placement Interviews will be scheduled for the first few weeks of May and Mandatory Parent Meeting will be held in late May for selected participants. A letter with more information about this meeting and interviews will be mailed to you upon submitting an application for the Program. Volunteer Orientation is required and will be held the first week of June.

****Application deadline is May 1, 2015.****

If you have any questions about the application or Junior Volunteer Program, please call Marketing at (706)481-7461.

PERSONAL INFORMATION

First _____ Middle _____ Last _____

Parent or Guardian name(s)_____

Address _____E-mail _____

City _____ State _____ Zip _____

Phone _____ Secondary Phone _____

EMERGENCY INFORMATION

Emergency Contact name _____

Relationship to you _____ Phone _____

QUESTIONNAIRE

- Do you have any physical conditions, which may limit your activities/abilities to perform any of the various volunteer jobs? If yes, please explain:

_____

- Special interests/hobbies/skills: _____

_____

- Please select the days you are available to volunteer and the times you are available. We ask that you please work a set schedule. Mark **am** (8:30-lunch), **pm** (lunch – 4:30) or **all** (for all day) next to the days below:

_____Monday _____Tuesday _____Wednesday _____Thursday _____Friday

EDUCATION/COMMUNITY INVOLVEMENT/VOLUNTEER EXPERIENCE

School: _____ Grade: _____

Courses currently taking, school activities, clubs, honors, etc. _____

_____

_____

- Do you have plans to continue your education after high school? If yes, what course of study do you want to pursue?_____

_____

- If known, what career do you hope to pursue as an adult? _____
- List any community affiliations (church, civic groups, etc.) _____

_____

_____

_____

- Are you seeking volunteer work as a requirement for any of the above activities/groups? If yes, please explain:

_____

_____

- Have you ever volunteered in the past before (school, civic)? If yes, please explain:

_____

_____

OTHER

- How did you hear about our Teen Volunteer Program? _____

_____

- Do you have any friends, relatives, acquaintances employed by or volunteering at the hospital?

  If yes, please list: Yes [ ] No [ ]

Name Position Relationship

_____

_____

_____

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

_____

_____

_____

_____

_____

_____

_____

DEPARTMENT PREFERENCE

Please select three areas you are interested in volunteering in:

___ Admitting
___ Central Supply
___ Day Surgery/PACU
___ Emergency Room
___ Employee Health
___ Endoscopy
___ Engineering
___ Food and Nutrition
___ Human Resources
___ Information Desk
___ Nursing Administration
___ Nursing Units
___ Quality
___ Radiology
___ Wound Healing Center

PARENTAL/GUARDIAN SIGNATURE

I hereby permit my 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 and understand that I will be informed if the test is positive. I further release the hospital from any legal or other responsibilities for any injuries, act, or incidents involving the volunteer.

Parent/Guardian Signature _____ Date _____

Phone Number _____

TEEN VOLUNTEER APPLICANT SIGNATURE

I hereby submit my application and letter of reference for the Teen Volunteer Program. I agree to a drug test for participation in this program and understand that a positive test results will be provided to my parent/guardian. I understand that the Volunteer Services Director makes all regular assignments, based on a personal interview and the interests of each prospective teen volunteer. I agree to abide by the policies and procedures of the Volunteer Services Department and understand that if selected I will be upheld to a **commitment of 75 hours**.

Confidentiality Agreement:
I understand and agree that, in the performance of my duties as a teen volunteer, I must hold patient / medical information in confidence. Information should not be discussed with any individuals including co-workers, other volunteers or family. I also understand that any violation of patient confidentiality will result in termination from the volunteer program.

Teen Signature _____ Date _____

Phone Number _____

Please mail signed application and letter of recommendation to:
Trinity Hospital of Augusta, c/o Volunteer Coordinator
2260 Wrightsboro Road
Augusta, GA 30904
Remember, application deadline is May 1, 2015.