

Junior Volunteer Application Form

Name _____ Date _____

Address _____ Telephone Number _____

City _____ State _____ Zip Code _____

Home Phone Number (____) _____ Cell Phone Number (____) _____

Birthdate _____ (must be 14+, 9th grade +) E-mail _____
(Month) (Day) (Year)

Name of School	Circle last year completed						Graduation Year	Current Interest
	7	8	9	10	11	12		

Parent/Guardian's Name _____

Home Phone Number (____) _____ Work Number (____) _____

Cell Phone Number (____) _____ Relationship _____

Are there any activities that may make it difficult for you to be a Junior Volunteer?

Activity	Dates/Times
Sports	
Music	
Drama	
Job	
Other	

Put an "X" on all times you are available to volunteer. Volunteers will only be asked to commit to one time per week.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning							
Afternoon							
Evening							

Denise Berscheid, CAVS
 Director, Volunteer Services
 (574) 335-2410
 5215 Holy Cross Parkway
 Mishawaka, IN 46545
 berschd@sjrmc.com

Would you be interested in working special events, community outreach projects, and fundraising events?
 Yes No

How did you learn about the Junior Volunteer Program? (Check all that apply)

- Employee
- Other volunteer
- School
- Newspaper
- Radio
- Other

Personal and Professional Reference:

Please enclose a letter of recommendation or have the included recommendation form completed and return with your application. Applications without a completed letter or reference or recommendation form will not be considered. A relative may not write letters and forms. We also ask for an attendance record for school, or have the attached Attendance form filled by a guidance counselor or teacher.

Please provide the name of an additional individual (excluding relatives) who may be contacted for a reference:

Name _____ Relationship _____

Address _____

City _____ State _____ Zip Code _____

Home Phone Number (____) _____ E-mail _____

Failure to fully and truthfully complete this application may result in the denial of volunteer service or termination from the services. Saint Joseph Regional Medical Center is not obligated to provide placement, nor are you obligated to accept the position offered.

AGREEMENT: I agree to take the prescribed training provided for Junior Volunteers and to follow the guidelines outlined by the Director of Volunteer Services. I agree to report to my volunteer assignment when scheduled. I agree to uphold the purpose and policies of the Department of Volunteer Services and Saint Joseph Regional Medical Center. To the best of my knowledge, the information in this application is accurate and correct.

DATE _____ APPLICANT'S SIGNATURE _____

Saint Joseph Regional Medical Center is committed to equal opportunity volunteer placements.

QUESTIONNAIRE

What are your career interests? Are you thinking about a career in healthcare? _____

What school, church or community activities have you participated in the last year? _____

What are some of your hobbies/sports? _____

What do you hope to gain from your volunteer experience? _____

When you think about volunteering, what types of things interest you? _____

What about a health care setting appeals to you? _____

What are some of your concerns or questions about being a volunteer? _____

HEALTH RECORD

THE FOLLOWING MUST BE ANSWERED BY PARENTS OR GUARDIAN:

NAME OF CHILD *(please print)* _____

Date of birth _____ Social Security Number _____

Name of Parent/Guardian _____

Has your son/daughter experienced good health for the last five years? _____

Are there any physical limitations we need to accommodate? _____

Family Doctor's Name _____

CONSENT FOR TUBERCULOSIS SCREENING FOR VOLUNTEERS UNDER THE AGE OF 18

Saint Joseph Regional Medical Center, Inc. requires documentation of an initial** two-step and annual tuberculosis (TB) screening for all volunteers. In order for your adolescent to work as a volunteer at Saint Joseph Regional Medical Center, Inc., please provide the below documentation. These records can often be obtained from your adolescent's personal physician, health department, and/or school. Documentation can be faxed to Employee Health Services at 574-472-6235 or brought to the Volunteer Orientation.

REQUIRED DOCUMENTATION

1 PPD (TB) skin test and result within the past 12 months

*or for those with a history positive TB skin test, please provide documentation of the positive skin test and a
Chest X-ray report showing no evidence of active TB*

If my adolescent does not have the above documentation, I authorize Saint Joseph Regional Medical Center, Inc. to give my child a TB skin test or to obtain a chest x-ray, at no cost to me. I understand that this is a requirement in order for my child to be able to work as a volunteer at SJRMC, Inc.

Signature of Parent or Guardian: _____
(Name) (Date)

Printed Name of Parent or Guardian: _____

Your signature indicates your approval for your child's participation in the junior volunteer program, your acknowledgement that she/he is in good health, and you consent for a TB screening. It also indicates approval for his/her reference certification, and completion of a State of Indiana background study form if necessary. If you have any questions, please contact volunteer services at 237-7242.

*(*Your child's birth date and social security number is needed only to enter his/her tuberculosis test or chest x-ray results into the computer. This private data will not be given out to anyone else or used for any other purpose by Employee Health Services.)*

*(**You child will receive two TB tests. The first one at the orientation and the second will be administered within 2 to 4 weeks after the first one.)*

VOLUNTEER RECOMMENDATION FORM

This form should be completed by a personal or professional reference and submitted with your volunteer application. Person completing form may not be a relative.

Volunteer Applicant's full name _____

Person giving reference (full name) _____

Reference address _____

Relationship to applicant _____ Length of acquaintance _____

Would you recommend this individual to be in a hospital setting? (check one) Yes No

Why? _____

If you had a family member who was a patient of Saint Joseph Regional Medical Center would you feel comfortable with this person playing or interacting with your child or family member? (check one) Yes No

Why? _____

Please describe applicant's interpersonal relationship skills _____

Please describe applicant's ability to follow through on commitments _____

Is there any additional information you would like to share about this applicant? _____

Reference signature _____ Date _____

Volunteer Attendance Form

A guidance counselor, school administrator or teacher should complete this form. It must also be submitted with your volunteer application. **Person completing form may not a relative.**

Volunteer Applicant's full name _____

Person giving reference (full name) _____

Reference address _____

Relationship to applicant _____ Length of acquaintance _____

Please check the appropriate boxes in each category

	Excellent	Good	Fair	Poor
Attendance				
Punctuality				

Is there any additional information that should be taken in consideration about the student's attendance, and punctuality?

Printing Instructions

Title: Junior Volunteer Application Form

Entity: South Bend

Printer Info: 20# White
Black ink
2 sides
H-T-H
Staple upper left hand corner

PDF File in Forms Directory

of pages: 6