

APPLICATIONS NOT ACCEPTED AFTER MAY 14, 2010

ST. CATHERINE HOSPITAL
SUMMER VOLUNTEEN APPLICATION
Shari Brandenburg, Volunteer Coordinator
272-2522
sharibrandenburg@catholichealth.net

(Please Print Plainly)

Date _____

Name: _____ Birth date _____

Address: _____ Telephone: _____

City _____ State _____ Zip _____

Email Address _____ Cell Phone _____

Driver's License Number _____ (Required) Social Security # _____ (Required)

School Name: _____ Grade (2010) _____

Parents:

Father's Name: _____ Telephone: _____

Cell Phone _____

Mother's Name: _____ Telephone: _____

Cell Phone _____

How did you learn of the Volunteen program at St. Catherine Hospital? _____

List your community and school activities (Church, scouting, sports, organizations, Honors, etc.):

List any past work or volunteer experience: _____

The VolunTeen program will be held from 9 AM to 12 PM, Monday, Tuesday, Wednesday and Thursday.

Do you have any friends or relatives who volunteer or are employed at St. Catherine Hospital? (List names) _____

Why are you interested in doing volunteer work? _____

What are your personal goals? _____

List special skills you have and wish to share: _____

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

In order to be considered for the St. Catherine Hospital VolunTeen Program, we need a **letter of recommendation** from a teacher, advisor, or other significant adult (not a family member) a **TB test** (we will provide you one at no cost), **Dates of MMR (Measles, Mumps and Rubella)**

1) _____ 2) _____ and be between the **ages of 15-18**

Do you understand that there are rules and regulations governing volunteer service in the hospital? _____ Are you willing to accept them? _____

Please indicate the dates you will be gone during the VT Program (vacation, camps, etc.)

Please Read The Following Carefully And Sign Below

I affirm that the information that is provided on this application is true and complete. I understand that before I begin my VolunTeen service, I will complete the application requirements, sign the release of information form, attend orientation, and any subsequent training sessions.

If selected to become a St Catherine Hospital volunteer, I understand the necessity of maintaining, as privileged and confidential, all information which I may learn about SCH patients. This includes, but is not limited to, patient diagnoses, courses or care and treatment, prognoses, personal lives, relationships and concerns, family matters and all information contained between patients and SCH staff, between patients and volunteers, or between physicians, and SCH staff in regards to any patient

Signature of Applicant

Date

Consent of Parent/Legal Guardian

I hereby authorize St. Catherine Hospital (SCH) to medically treat or manage any injury sustained, if after reasonable effort, I cannot be reached. This release is in effect for the period of time the applicant serves as a SCH VolunTeen

I consent for my child to serve as a VolunTeen at SCH and consider him/her capable of undertaking the responsibilities of a health center VolunTeen and grant permission for participation in events without requiring additional permission forms. I certify that he/she is at least 15 years of age.

I understand that a Tuberculosis skin test is required to allow my child to volunteer. Thereby, I give my permission for the staff of SCH to administer a TB Skin Test on my child.

I grant SCH Volunteer Services permission to use photographs taken of my child for publication to promote volunteerism.

I also give SCH permission to release my child's information in order to perform a background check on the VolunTeen. I understand my child's acceptance into the VolunTeen program is dependent upon the outcome of this background check.

Parent/Legal Guardian Signature

Date

FOR OFFICE USE ONLY:

App. Recd _____ TB Test Completed _____

References _____ Copy of MMR _____

VolunTeen Orientation Attended _____

Other _____