

Volunteer Services Department
TEENAGE VOLUNTEER APPLICATION
(Office Use Only)

Placed in _____ Date of interview _____
(Hospital & Service) (Date & Time)

PERSONAL INFORMATION

NAME _____ GRADE _____ AGE _____ SCHOOL _____

ADDRESS _____ CITY _____ ZIP _____

PHONE (Home) _____ BIRTH DATE _____ S.S.# _____

CELL PHONE: _____ E-MAIL _____

NAME OF PARENT OR LEGAL GUARDIAN Circle whose address: Mother / Father / Legal Guardian

NAME _____ ADDRESS _____

HOME PHONE# _____ WORK PHONE# _____

PREVIOUS WORK EXPERIENCE

As a volunteer/List Organizations: _____

As a paid employee/List Organizations: _____

Special training, work experience, talent, skill, foreign language, computers, etc.:

VOLUNTEER INFORMATION

From the list of areas of service, please indicate which programs would be of interest to you:

1. _____ 2. _____ 3. _____

Based on your school and work schedule this summer, what kind of work schedule will work best for you in order to get the hours you need (check one):

___ One 4-hour shift a week: M T W Th F Sat Sun MORNING–AFTERNOON-EVENING

___ Several 4-hour shifts per week: M T W Th F Sat Sun MORNING–AFTERNOON-EVENING

(REFERENCES, CONDITIONS, CONSENT & COMMITMENT ON BACK)

PERSONAL REFERENCES

Applicant Name: _____

Ask either two of your teachers and/or your counselor for his/her recommendation and signature.

TEACHER AND/OR GUIDANCE COUNSELOR RECOMMENDATION

I recommend the above named applicant to serve within a hospital setting as a Teenage Volunteer.

Comments, if any: _____

Teacher Name (printed): _____ Teacher Signature: _____

Phone Number: _____

School: _____

Date: _____

WRITTEN RECOMMENDATION FOR _____

I recommend the above named applicant to serve within a hospital setting as a Volunteer. Comments:

Name (printed): _____ Relation to volunteer: _____

Phone Number: _____ Date: _____

VOLUNTEER PLEDGE OF COMMITMENT

1. I will consider all information confidential, which I may hear directly or indirectly concerning a patient, physician or any member of the hospital staff and I will not seek information in regard to a patient.
2. I agree to commit to at least 72 hours per year to volunteer at Florida Hospital. I will uphold the standards and traditions of the hospital as they are expressed in its Mission Statement and that of the Department of Volunteer Services.

SIGNATURE _____

DATE _____

VOLUNTEER CONDITIONS

1. I certify that the information on this application is true and complete to the best of my knowledge. I understand that any misrepresentation or omission of facts on this application will be sufficient cause for disqualification of this application.

I give permission for Florida Hospital to verify any information provided in this application and I authorize my past references or any other persons to answer all questions concerning my ability, character, reputation, and previous employment record. I release all such persons from any liability or damages resulting from having furnished such information.

2. Have you ever been convicted or found guilty of a felony offense? (Conviction of a crime will not necessarily deny volunteering. **A criminal background check is part of volunteering**). Yes No

If "YES", please explain all convictions: _____

SIGNATURE _____

DATE _____

PARENTAL CONSENT FORM To be completed by the parent/legal guardian:

I give permission for my son/daughter _____, who is at least 15 years old, to participate as a teenage volunteer at Florida Hospital. I understand that my son/daughter is making a commitment to serve as a volunteer and that I will support his/her participation, which includes reporting for

duty as scheduled, except in the event of illness. I understand that he/she will be assigned to an available service suitable to his/her age and capabilities.

SIGNATURE_____

DATE_____