



VOLUNTEER SERVICES APPLICATION
TEEN
(AGES 14-17)

PERSONAL INFORMATION

CONFIDENTIAL

First _____ Middle _____ Last _____

Parent or Guardian name(s) _____

Address _____ E-mail _____

Social Security Number _____ Birth date _____

(Social Security Number is required)

City _____ State _____ Zip _____

Phone _____ Cell 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? Yes [] No []

If yes, please explain _____

☛ Special interests/hobbies/skills: _____

6. Check when you are available to volunteer. Each shift is typically 4 hours***

Please Mark which SESSION you are applying for:

	<u>FALL (Sept – Dec)</u>	<u>WINTER (Jan - March)</u>	<u>SPRING (March - June)</u>	<u>SUMMER (June - August)</u>
[] Monday	___ 8:00 am – 12:00 pm	___ 12:00 pm – 4:00 pm	___ 4:00 pm – 8:00 pm	
[] Tuesday	___ 8:00 am – 12:00 pm	___ 12:00 pm – 4:00 pm	___ 4:00 pm – 8:00 pm	
[] Wednesday	___ 8:00 am – 12:00 pm	___ 12:00 pm – 4:00 pm	___ 4:00 pm – 8:00 pm	
[] Thursday	___ 8:00 am – 12:00 pm	___ 12:00 pm – 4:00 pm	___ 4:00 pm – 8:00 pm	
[] Friday	___ 8:00 am – 12:00 pm	___ 12:00 pm – 4:00 pm	___ 4:00 pm – 8:00 pm	
[] Saturday	___ 8:00 am – 12:00 pm	___ 12:00 pm – 4:00 pm	___ 4:00 pm – 8:00 pm	
[] Sunday	___ 8:00 am – 12:00 pm	___ 12:00 pm – 4:00 pm	___ 4:00 pm – 8:00 pm	

******Times and availability may vary depending on your department placement***

EDUCATION - COMMUNITY INVOLVEMENT - WORK EXPERIENCE

School: _____ Year in School: _____

Grade Point Average: _____

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: Yes [] No []

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

Yes [] No []

OTHER

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

• Do you have any friends, relatives, acquaintances employed by or volunteering at Deaconess?

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

Name

Position

Relationship

• Briefly explain why you want to join our Teen Volunteer Program at Deaconess Medical Center:

PLEASE CHECK ALL AREAS THAT YOU ARE INTERESTING IN VOLUNTEERING IN THE HOSPITAL:

Day Surgery ___ Cardiac Intensive Care Desk ___ Clerical/Office Support ___
Emergency Department ___ Gift Shop ___ Intensive Care Unit Desk ___
Information Desk/Guest Relations ___ Medical Records ___ Mailroom ___
Mother/Baby ___ Patient Care Floors ___ Pharmacy ___ Short Stay ___
Surgery Liaison Desk ___ Other Please Note: _____

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 result will be provided to my parent/guardian. I understand that the Volunteer Services Director/Coordinator makes all regular assignments, based on a personal interview and the interests of each prospective teen volunteer. I further understand that my volunteering is contingent upon checking of references furnished. I agree to abide by the policies and procedures of the Volunteer Services Department.

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.

Applicant Signature _____

Date _____

PARENTAL/GUARDIAN SIGNATURE

I hereby permit my son/daughter/charge _____ to participate in the Teen Volunteer Program. I 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 also give my permission to conduct a criminal background check. 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 _____ Secondary Phone _____

ATTENTION PARENT/GUARDIAN

Please include a copy of your child's IMMUNIZATION RECORDS with this application.

PLEASE MAIL OR FAX YOUR COMPLETED APPLICATION TO:

**Deaconess Medical Center
VOLUNTEER OFFICE
800 West Fifth Ave.
Spokane WA. 99210-0248**

**FAX NUMBER – 509-473-3148
OFFICE- 509-473-3058
509- 473-3767**

DEACONESS MEDICAL CENTER VOLUNTEER DEPARTMENT REFERENCE FORM

APPLICANT'S NAME: _____

NAME OF PERSON GIVING REFERENCE: _____
PLEASE NOTE-PARENTS OR RELATIVES ARE NOT AN ACCEPTABLE REFERENCE

RELATIONSHIP TO APPLICANT: _____

HOW LONG HAVE YOU KNOWN THIS APPLICANT? _____

Please evaluate the applicant in the following areas:

	OUTSTANDING	GOOD	FAIR	NEEDS IMPROVEMENT
1. Displays tact, patience and respect for others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Able to work with diverse populations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Is dependable and punctual.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Accepts responsibility and commitment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Accepts supervision in a positive way.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Able to accept change.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ADDITIONAL COMMENTS: _____

Signature: _____ DATE: _____

PRINT NAME: _____ PHONE: _____

MAY WE CONTACT YOU FOR ADDITIONAL COMMENTS? YES NO

**PERSON GIVING REFERENCE - PLEASE RETURN TO THE APPLICANT THE
COMPLETED REFERENCE FORM IN A "SEALED" ENVELOPE TO BE
INCLUDED IN HIS/HER APPLICATION PACKET. THANK YOU.**

If you have questions regarding this reference request please contact Volunteer Services- 509-473-3058 or 509-473-5639