

## JUNIOR VOLUNTEER APPLICATION

Application Date \_\_\_/\_\_\_/\_\_\_

<b>PERSONAL INFORMATION</b>
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Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Other Names Used: \_\_\_\_\_ Address: \_\_\_\_\_

Apt. \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

Soc. Security Number: \_\_\_\_\_ Current Grade: \_\_\_\_\_

School You Are Attending: \_\_\_\_\_

Physical/Medical Considerations: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship of Contact: \_\_\_\_\_

<b>PERSONAL REFERENCES (Should not be related to you; include at least 1 teacher.) PLEASE PROVIDE A REFERENCE LETTER FROM EACH PERSON in an envelope signed and sealed by the reference.</b>
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NAME: \_\_\_\_\_ Phone: \_\_\_\_\_

NAME: \_\_\_\_\_ Phone: \_\_\_\_\_

<b>PERSONAL SKILLS</b>
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Computer	Languages	Photography
Crafts	Newsletter Writing/Editing	Public Speaking
Fundraising	Musician	Teaching
Hospitality	Organizing Events	Human Resources
Marketing	Sales Clerk	Medical -Related
Other (Describe)		

**WORK EXPERIENCE**

Current Employer (If applicable): \_\_\_\_\_ **Hours Worked Per Week:** \_\_\_\_\_

**Previous Employer:** \_\_\_\_\_

Reason for leaving this employer: \_\_\_\_\_

**PREVIOUS VOLUNTEER WORK**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**RETURNING STUDENT:** Where have you worked/volunteered since leaving MCM last year? \_\_\_\_\_

\_\_\_\_\_

Reason for wanting to volunteer: **Please provide a one-page biography including motivation for wanting to participate in the Junior Volunteer Program and include with application.**

How did you learn about the Junior Volunteer Program? \_\_\_\_\_

Do you know anyone or are you related to anyone at Medical City McKinney? **NO** \_\_\_\_ **YES** \_\_\_\_ **If yes, provide name and relationship** \_\_\_\_\_

**What areas would be your preference in which to volunteer?**

Reception  Clerical  Patient Contact  Other

*I CERTIFY THAT THE INFORMATION IN THIS APPLICATION IS TRUE AND COMPLETE. I UNDERSTAND THAT IT MAY BE VERIFIED BY THE ORGANIZATION OR ANY AFFILIATE AND THAT A BACKGROUND CHECK WILL BE PERFORMED ON EACH CANDIDATE BEFORE BEING ACCEPTED INTO THE PROGRAM. SHOULD I BE ACCEPTED TO VOLUNTEER AND LATER IT IS FOUND THAT THE INFORMATION HEREIN IS SIGNIFICANTLY UNTRUE OR MISREPRESENTED, I UNDERSTAND AND AGREE THAT MEDICAL CITY MCKINNEY IS RELIEVED OF ALL COMMITMENTS AND THAT I AM SUBJECT TO IMMEDIATE DISMISSAL. I ALSO UNDERSTAND THAT I WILL NOT RECEIVE PAYMENT FOR MY SERVICES AS A VOLUNTEER. I ALSO ACKNOWLEDGE THAT CELL PHONES ARE NOT ALLOWED WHILE VOLUNTEERING IN VARIES DEPARTMENTS.*

Signature – Teen Volunteer: \_\_\_\_\_ Date: \_\_\_\_\_

Signature – Parent or Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

