JUNIOR VOLUNTEER APPLICATION

Application Date____/____/_____

PERSONAL INFORMATION

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: _____

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.

NAME: _____ Phone: _____

NAME: _____ Phone: _____

PERSONAL SKILLS

☐	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 MCDC 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 Decatur? **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 DECATUR 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: _____