St.Vincent Health
Saint John's Health System

Junior Volunteer Application Form

Name _____ Date _____
(Last) (First) (Middle)

Address_____City_____State_____Zip _____

E-mail Address _____ Social Security #_____

Age_____Date of Birth_____Home Phone _____
Month Day (Year optional)

Parent or Guardian's Name_____Work Phone _____

CONTACT IN CASE OF EMERGENCY:

_____
(Name) (Relationship) (Home Phone) (Work Phone)

Name of School _____ Grade (circle) 9 10 11 12

Graduation Year_____Career Interest _____

Present Employment _____

Work Phone_____Hours _____

Volunteer Experience _____

Interests, Skills, School Activities _____

_____

Family Physician_____Phone _____

Do you have a condition which would prevent you from performing the essential functions of your volunteer service position?

Yes_____ No_____ If yes, explain _____

_____

REFERENCES: Please choose your references from among the following: family physician, teacher, minister, principal, employer, adult volunteer here.

1. Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

2. Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

I want to volunteer: _____Summer's Only _____Winter's Only _____Year Round

Applicant's Signature _____ Date _____

I give my permission for my son/daughter to do volunteer work at Saint John's Health System. I also give permission for my son/daughter to be given a free tuberculosis test and/or chest X-ray to adhere to the rules of infection control at the hospital.

Parent's or Guardian's Signature _____ Date _____

Opportunities for volunteers are provided without regard to religion, creed, race, national origin, age, or sex.

Orientation preference: Fall_____ Spring_____

Confidential School Recommendation
For Junior Volunteer

PARENTAL CONSENT: I authorize the release of information from my son/daughter's school records to the Volunteer Services Department of Saint John's Health System.

Parent's Signature_____Date _____

Dear Counselor or Teacher:

Each student who applies for volunteer work must have a recommendation from school. We would appreciate your evaluation and comments to help us choose candidates who will best benefit from our program and serve our organization and the recipients of our services. This information will be kept confidential. Please return the completed form to me at the address below at your earliest convenience. Thank you for your assistance.

Judy Lippman
Director of Volunteer Services
Saint John's Health System
2015 Jackson Street
Anderson, IN 46016

CONFIDENTIAL RECOMMENDATION FOR JUNIOR VOLUNTEER

Student's Name _____ Grade in School _____

	Excellent	Good	Average	Below Average
Attendance	_____	_____	_____	_____
Scholastic Record	_____	_____	_____	_____
Dependability	_____	_____	_____	_____
Courtesy	_____	_____	_____	_____
Willingness	_____	_____	_____	_____
Initiative	_____	_____	_____	_____

Comments:

_____

_____

_____

_____

_____

Signature _____

Title _____

School _____

Date _____