



**VOLUNTEER SERVICES  
JUNIOR VOLUNTEER APPLICATION**

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
(Last) (First) (Middle)

Address: \_\_\_\_\_  
(Street/P.O. Box #, Apt. #) (City) (State) (Zip)

E-mail Address: \_\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

Birth Date: (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_ Parent/Legal Guardian: \_\_\_\_\_

Previous volunteer experience (if any), where and who was your supervisor?: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List skills and/or qualifications you feel would especially fit you for volunteering:  
Filing  Typing  Computers  Other: \_\_\_\_\_  
\_\_\_\_\_

Have you ever been convicted of a felony? Yes  No  If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Do you drive? Yes  No  Are you dependent upon a ride to and from the hospital? Yes  No

Person to contact in case of illness or emergency: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone (if applicable) (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**AVAILABILITY:**

Please provide us with all days and times that you are available to volunteer your time. Listing all days and times that you are available will enable us to identify what current volunteer opportunities we may have that fit your schedule. Typically, volunteers are scheduled in one to four hour shifts. Other areas may be adapted to the department's and volunteer's needs at the discretion of the department and the Volunteer Services Office.

Monday: \_\_\_\_\_ Tuesday: \_\_\_\_\_

Wednesday: \_\_\_\_\_ Thursday: \_\_\_\_\_

Friday: \_\_\_\_\_ Saturday: \_\_\_\_\_

Sunday: \_\_\_\_\_

(Over)

**We would like to know more about you!**

Please list any medical/health problems that you may have that would prevent you from performing certain duties (i.e., transporting patients, lifting, etc.): \_\_\_\_\_

**Interests:** Please circle those areas in which you are interested in volunteering. Specific duties in these areas will be addressed during your interview.

- |                     |                  |
|---------------------|------------------|
| Clerical Assistance | Information Desk |
| Escort Service      | Gift Shop        |
| Rehabilitation Unit |                  |

PLEASE NOTE: Volunteer services are not always available in every area. Open volunteer positions are posted to inform any volunteers interested in changing services or volunteering additional hours.

Please describe the perfect Junior Volunteer assignment for you: \_\_\_\_\_

**References:** (Please do not list relatives)

1. Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

2. Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

By signing this application (below), I affirm that I am aware that all patient-related material and information is **strictly confidential** and if selected as a volunteer with Carlisle Regional Medical Center under no circumstances will I ever discuss patient-related information with anyone. Any breach of this trust may result in **immediate and permanent termination** of my volunteer status. I verify that if I am selected to participate in the program, my position title will be that of **Junior Volunteer** and that I will perform the services assigned with no promise or expectation of monetary rewards. I understand that I must participate in orientation/training program(s) including the administration of a PPD (TB) test, wear the designated uniform and identification badge while on duty and that failure to do so will result in disciplinary action. As a Junior Volunteer, my behavior and attitude will be professional and courteous at all times and I will perform all duties in a timely and efficient manner without compromising any patient's safety or health.

On an annual basis, a PPD (TB) test is required for all volunteers. By signing this form, you give consent for future PPD testing. Consent can be revoked at any time by contacting the Director of Volunteer Resources.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

By signing this application (below), I affirm that I am aware that the above signed applicant has my permission to volunteer for Carlisle Regional Medical Center and that they are at least 14 years old.

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_