



<i>For Internal Use:</i>	
Certifications	_____
Community Service	_____
Drug Test	_____

TEEN (AGES 14 – 17)
VOLUNTEER SERVICES APPLICATION

Thank you for your interest in becoming a Teen Volunteer. Please return your application, signed by you and your parent or guardian, along with a letter of recommendation to the Volunteer Services Department. A drug test is a mandatory requirement before volunteer placement can begin.

PERSONAL INFORMATION

First _____ Middle _____ Last _____
 Parent or Guardian name(s) _____
 Address _____ E-mail _____
 City _____ State _____ Zip _____
 Phone _____ Secondary Phone _____
 Date of birth _____ Social Security No. _____

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: _____

 Please select the days you are available to volunteer:
 ___Monday ___Tuesday ___Wednesday ___Thursday ___Friday ___Saturday

Continued



EDUCATION/COMMUNITY INVOLVEMENT/WORK EXPERIENCE

School: _____ Grade: _____

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 the hospital? If yes, please list: Yes [] No []

Name	Position	Relationship

Briefly explain why you want to join our Teen Volunteer Program: _____

Continued



SPECIAL SKILLS/INTERESTS

Check the items, in which you have abilities or experience.

- | | |
|--|--|
| <input type="checkbox"/> Typing | <input type="checkbox"/> Art (painting or other) |
| <input type="checkbox"/> Filing | <input type="checkbox"/> Sewing/Needlework |
| <input type="checkbox"/> Computer Operations | <input type="checkbox"/> Gardening |
| <input type="checkbox"/> Audio Visual | <input type="checkbox"/> Crafts |
| <input type="checkbox"/> Photography | <input type="checkbox"/> Calligraphy |
| <input type="checkbox"/> Music | |

Other/Miscellaneous Skills – please list:

_____	_____	_____
_____	_____	_____

PARENTAL/GUARDIAN SIGNATURE

I hereby permit my son/daughter/charge _____ to participate in the Teen Volunteer Program. I also 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 further release the hospital from any legal or other responsibilities for any injuries, act, or incidents involving the volunteer.

Parent/Guardian Signature _____ Date _____

Phone Numbers _____

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 results will be provided to my parent/guardian. I understand that the Volunteer Services Director makes all regular assignments, based on a personal interview and the interests of each prospective teen volunteer. 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.

Teen Signature _____ Date _____

Phone Number _____



Please returned signed application to:

Lisa Wilson - 2485 Highway 644, PO Box 769 Louisa, KY 41230.

If you have any questions, please contact:

Lisa Wilson, Volunteer Coordinator, at 606/638-9451 ext 5557 or Lisa_Wilson2@chs.net.