Decatur Morgan Hospital

TEEN VOLUNTEER APPLICATION

Name:_____
Last *First* *Middle Initial*

Address:_____

City:_____State:_____Zip:_____

Phone:_____ Cell Phone:_____ Carrier: (ex. Verizon, AT&T) _____

Birthdate:_____ T-Shirt Size:_____

Email: _____

School attending: _____

Grade currently completed:_____GPA:_____

Are you interested in a health career? _____ If yes, which?_____

Other reason(s) why you are interested in being a volunteer: _____

_____

Will your schedule permit you to complete the 10 week program, other than time away for vacation? ❑ Yes ❑ No

If no, please explain._____

Have you participated in other community volunteer organizations? ❑ Yes ❑ No

If yes, which and list duties: _____

How did you become interested in our program?_____

_____

SPECIAL SKILLS/INTERESTS

In the order of preference (1-3), please select areas of interest.

( ) Gift Shop
( ) Emergency Room Decatur Campus
( ) Food Services Decatur Campus
( ) PACU Decatur Campus
( ) Respiratory Therapy Decatur Campus
( ) Admissions Decatur Campus
( ) Pre-Admission Testing Decatur Campus
( ) Rehab Access Decatur Campus
( ) Labor and Delivery Decatur Campus
( ) Emergency Department Parkway Campus
( ) Admissions Parkway Campus

Volunteer hours are between 8:00 am and 2:00 pm.

Please circle days you are available: Monday Tuesday Wednesday Thursday Friday

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CONFIDENTIALITY STATEMENT

I understand that as a Decatur Morgan Volunteer, I will not be paid for services**.** I agree, in the performance of my duties, I must hold in strictest confidence any observations I may make or hear regarding patients, patients' families or hospital staff.

I understand that intentional or involuntary violation of confidentiality may result in disciplinary action including termination.

Date:_____ Applicant: _____

FOR PARENT TO COMPLETE

Do you object to your child having a TB skin test? ❑ Yes ❑ No

Parental Consent:
I hereby agree to allow my child to serve as a volunteer at Decatur Morgan Hospital. I fully understand in the course of duties my child will be permitted to enter patient areas and/or patient rooms. I understand that as a volunteer my child will not receive pay for services.

Date:_____ Parent or Legal Guardian:_____

EMERGENCY CONTACT

Name:_____

Address:_____

Contact Number: _____ ❑ Cell ❑ Home ❑ Work

Family Doctor:_____ Phone:_____

DO NOT WRITE BELOW THIS DOTTED LINE

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Date Interviewed:_____ Interviewed By:_____

Comments:_____
_____
_____
_____