



Teen Volunteer Application

NAME _____ SS# _____ DATE _____
Last First MI

ADDRESS _____
Number/Street City State Zip

EMAIL ADDRESS _____

HOME PHONE _____ DATE OF BIRTH _____

SCHOOL _____ PRESENT GRADE _____ EXPECTED GRADUATION YEAR _____

PARENTS/GUARDIAN NAME _____ WORK PHONE _____

Who referred you to WCMC? _____

Reason for volunteering: _____ Friends also volunteering: _____

PREVIOUS WORK/VOLUNTEER EXPERIENCE

Paid Work Experience

Volunteer Experience

Where _____

Where _____

Address _____

Address _____

City/State _____

City/State _____

Zip _____ Phone _____

Zip _____ Phone _____

HOBBIES, SPECIAL SKILLS, CAREER INTERESTS

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TIME AVAILABLE

Day _____ Time _____

Day _____ Time _____

ASSIGNMENT PREFERENCE

REFERENCE: (Adult, not member of family)

NAME _____ PHONE _____

ADDRESS _____
Number/Street City State Zip

FAMILY/PERSONAL PHYSICIAN'S NAME _____ PHONE _____

In order to volunteer at WCMC the following steps must be taken:

1. Have the appropriate people complete both sections below.
2. Submit with this application an up-to-date immunization record. The M-M-R (measles-mumps-rubella) Vaccine had to have been given within the 1980s or 1990s.
3. Proof of TB Skin Test within the past year.
4. Complete and send the attached Emergency Medical Form.

Parent's or Guardian's Consent

I, the undersigned, herewith consent that my daughter/son _____ may serve the West Chester Hospital as a Teen Volunteer and expressly release the West Chester Hospital from any and all claims, which might arise out of the service as a volunteer.

Signature _____
Parent or Guardian

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SCHOOL RECOMMENDATIONS

School Principal, Counselor or Teacher: Complete and return to student or mail to West Chester Hospital, Volunteer Services, 7700 University Drive, West Chester, OH 45069.

The applicant has expressed desire to do volunteer work at The West Chester Hospital. Kindly check the following, giving your confidential opinion of the applicant as a responsible hospital volunteer. **Rank from 1-5 with 5 as highest rating.**

Dependability	1_____	2_____	3_____	4_____	5_____
Scholastic Standing	1_____	2_____	3_____	4_____	5_____
Mental Alertness (ability to grasp oral or written instructions)	1_____	2_____	3_____	4_____	5_____
Punctuality	1_____	2_____	3_____	4_____	5_____
Quality of Work	1_____	2_____	3_____	4_____	5_____

Comments:

Student's Name _____ School _____

Your Signature _____ Title _____



EMERGENCY MEDICAL AUTHORIZATION

Volunteer's Name _____

Volunteer's Home Address _____

Volunteer's Home Phone _____

Parent or Guardian's Name _____

Parent or Guardian's Home Address _____

Parent or Guardian's Phone (Home/Cell) _____ (Work) _____

The purpose of this document is to enable parents and guardians to authorize the provision of emergency medical treatment for minor volunteers who become ill or injured while at **West Chester Hospital** when the parents or guardians of such volunteers cannot be reached.

In the event reasonable attempts to contact one of the above persons, at the telephone numbers listed, have been unsuccessful, I **hereby give my consent for:**

- 1) the administration of any treatment deemed necessary by the following preferred physician, Dr. _____, phone number _____; or the following preferred dentist, Dr. _____, phone number _____, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and
- 2) the treatment of the minor volunteer at **West Chester Hospital** or any other hospital to which the minor volunteer may be transferred.

This authorization does not cover major surgery unless the medical opinion of two other licensed physicians or dentists, concurring in the necessity of such surgery, are obtained prior to the performance of such surgery. Facts concerning the minor volunteer's medical history including allergies, medications being taken and any physical impairment to which the physician should be alerted are the following:

Parent or Guardian Signature

Address

Date

I do not give my consent for emergency medical treatment to my child. In the event of illness or injury requiring emergency medical or dental treatment, I wish **West Chester Hospital** to take no action or to do the following:

Parent or Guardian Signature

Date

Address