MEMORIAL HOSPITAL
UNION COUNTY

Junior Volunteer Application

Minimum Age 14

Name _____
(Last) *(First)* *(Middle Initial)*

Preferred Nickname _____ **Date** _____

Address _____
(Street) *(City)* *(State)* *(Zip)*

Home Phone _____ **Cell Phone** _____ **Date of Birth** _____

Email Address _____

Last 4 Digits of Your Social Security Number _____

Employment Information ❒ **I am not employed.**

Employer _____ **Occupation** _____

May we call you at work? ❒ **Yes** ❒ **No** **Phone Number:** _____

Parent's Name _____ **Work phone** _____

Person to be notified in case of emergency: _____

Relationship _____**Phone (**_____**)**_____

References: Please list two references from among the following: family physician, teacher, minister, principal, employer, adult volunteer from Memorial Hospital of Union County. Ask them to sign below and write a letter of reference regarding your character, general attitude, dependability, personality and ability to cooperate. Attach the letters to this application.

1. **Name:** _____ **Relationship:** _____
   Address: _____ **Phone:** _____
2. **Name:** _____ **Relationship:** _____
   Address: _____ **Phone:** _____

Medical Reference (Primary care physician or specialist):

Name _____ **Phone** _____

Address: _____ **City:** _____ **Zip** _____

Do you have any health limitations? ❒ **Yes** ❒ **No**

If yes, please describe: _____

JUNIOR VOLUNTEER APPLICATION

Education:

Name of School _____ **Grade (Circle) 8 9 10 11 12**

Graduation Year _____ **Career Interest** _____

Gender: ❒ **Male** ❒ **Female**

Ethnicity: ❒ **White (Caucasian)** ❒ **African American** ❒ **Asian** ❒ **Hispanic**
❒ **Mixed race** ❒ **Native American** ❒ **Other**

Please indicate which days and times you are available:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
❒ Breakfast ❒ Lunch ❒ Dinner	❒ Breakfast ❒ Lunch ❒ Dinner	❒ Breakfast ❒ Lunch ❒ Dinner	❒ Breakfast ❒ Lunch ❒ Dinner	❒ Breakfast ❒ Lunch ❒ Dinner	❒ Breakfast ❒ Lunch ❒ Dinner	❒ Breakfast ❒ Lunch ❒ Dinner

I want to volunteer: ❒ **Summers only** ❒ **Throughout the year**

I want to volunteer because... _____

_____

How did you find out about our volunteer program? _____

_____

Confidentiality Statement

I will consider as confidential all information that I may gain in my volunteer position, directly or indirectly, concerning patients, doctors, staff, employees, families, and volunteers. I understand that my volunteer service will be terminated as a result of any breach of confidentiality.

Applicant's Signature: _____ **Date:** _____

Parent's Signature: _____ **Date:** _____

Your signature indicates your approval for your child's participation in the junior volunteer program, your acknowledgement that he or she is in good health, and your consent for us to contact your child's physician in case of emergency.

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