OLYMPIC MEDICAL CENTER

TEEN VOLUNTEER SERVICES APPLICATION

939 Caroline Street
Port Angeles, WA 98362

Thank you for your interest in becoming a Volunteen. Please return your application, signed by you and your parent or guardian, along with a letter of recommendation to the Volunteer Services Department. Placements for the Volunteen Program begin June 2010. Volunteer Orientation is required and will be held [to be announced].

PERSONAL INFORMATION

First_____Middle_____Last_____
Parent or Guardian _____
Address _____ E-mail _____
City _____ State _____Zip_____
Phone _____ Secondary Phone _____
Date of birth _____Last 4 digits Social Security No. _____

EMERGENCY INFORMATION

Emergency Contact name

_____
Relationship to you _____ Phone _____

QUESTIONNAIRE

_____
Special interests/hobbies/skills:

_____
_____

Volunteer shift are from 9:00 a.m. – Noon. Noon – 3:00 p.m.

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

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 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 [ ]

_____

_____

How did you hear about our Volunteen 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:

_____

_____

ACADEMIC REFERENCE (school counselor, principal or teacher)

Please attach a letter to your application.

SKILLS/INTERESTS

___ Typing

___ Filing

___ Computer Operations

___ Audio Visual

Other/Miscellaneous/Please List

_____

_____

_____

PLEASE READ THE FOLLOWING BEFORE SIGNING:

Your placement as a volunteer with Olympic Medical Center is dependent upon the acceptance by Volunteer Services and completion of the hospital health requirements along with the report from the Washington State Patrol request for criminal history information (Child/Adult Abuse Information Act RCW 43.43.830). Olympic Medical Center is required to run a check on all volunteers and employees.

I hereby declare that all the information I have given above is true to the best of my knowledge. I further understand that my volunteering is contingent upon checking of references furnished. I consent to and authorize the hospital and its personnel to request any information concerning work and personal references as indicated on this application for volunteering. I hereby release all parties and persons connected with any request for information from all claims, liabilities, and damages for whatever reason arising out of furnishing such related information.

I am aware that the participation in the Volunteer Program may have risk of injury or illness. I understand there is no compensation or insurance benefit provided to me in the event that become injured or ill in the course of my volunteering. I acknowledge and accept the risks inherent to the Volunteer Program and working in a healthcare setting, and with this knowledge in mind, agree to participate in the Volunteer Program.
I understand I will not be paid for my volunteer services. I also agree to abide by ALL volunteer and hospital program policies and procedures.

_____ I give my permission to be photographed and used for press releases
Initials

TEEN VOLUNTEER APPLICANT SIGNATURE

Name_____Date _____
Phone Number _____

PARENTAL/GUARDIAN SIGNATURE

I hereby permit my son/daughter/charge _____to participate in the Volunteen Program. I further release the hospital from any legal or other responsibilities for any injuries, act, or incidents involving the Volunteen.

Parent/Guardian Signature _____

Date _____

Telephone Numbers _____ _____ _____

Please return signed application to:

Olympic Medical Center
939 Caroline Street
Port Angeles, WA 98382
If you have any questions, please contact Kathy Coombes, Volunteer Coordinator
(360) 565-9110
OR
kcoombes@olympicmedical.org