

COMMUNITY MEDICAL CENTER
JUNIOR VOLUNTEER APPLICATION

Date of Application _____ Age at time of application _____

*We would appreciate you filling in and returning this application to the Volunteer Office.
We will process and contact you to arrange an interview.
(please print)*

PERSONAL INFORMATION

SEX: MALE FEMALE

Last name First M.I. Nickname

Address _____ Home phone _____
Street

City State Zip Code E-mail address _____

Birth Date _____ Social Security No. _____

Please give us the name, address, and telephone number of someone who can be notified
in case
Of emergency

Name Address Relationship

Home phone Work phone

BACKGROUND

Current School _____ Grade: _____ Guidance Counselor: _____

Address _____ Phone# _____

VOLUNTEER EXPERIENCE

Have you ever volunteered before? Yes ___ No ___ If yes, for what organization (s)?

_____ From: _____ To: _____

_____ From: _____ To: _____

Were you referred to Community Medical Center by a friend/relative: Yes ___ No ___

I am interested in volunteering for the following reasons: _____

COMMITMENT

Volunteer work preferred:

() Working directly with patients () Clerical () Reception () Delivery

Are you available year-round? Yes ___ No ___ If no, when? _____

Time of day and Day(s) available for volunteer service:

| | Mon | Tues | Wed | Thurs | Fri | Sat | Sun |
|-----------|-----|------|-----|-------|-----|-----|-----|
| Morning | | | | | | | |
| Afternoon | | | | | | | |
| Evening | | | | | | | |

On what date can you begin your volunteer service? _____

I, the Junior Volunteer applicant, agree to adhere to the rules and regulations set forth by the Volunteer Department of Community Medical Center.

Applicant Signature

Date

Parent's/Guardian's Permission

I hereby give my permission for my daughter/son to join the Junior Volunteer Program at Community Medical Center and to work as a Junior Volunteer in whatever services she/he is assigned at the Medical Center. I realize the responsibility of the organization and will cooperate with my daughter/son to comply with its regulations, which includes providing her/his transportation and seeing that she/he faithfully maintains her/his scheduled time of service.

Parent's/Guardian's

Signature: _____ Date: _____

COMMUNITY MEDICAL CENTER
VOLUNTTER RESOURCE CENTER

REFERENCE RELEASE

PLEASE LIST THE NAMES, ADDRESSES AND PHONE NUMBER OF TWO
REFERENCES.

| |
|--|
| |
| |

PLEASE SIGN AND DATE THIS RELEASE

I authorize Community Medical Center Volunteer Resource Center to contact references from an adult, other than family members, such as a teacher, coach, minister, or director of organization you belong to.

Signature of parent/guardian

date

Dear Parent/Guardian:

Your daughter/son is applying to become a Junior Volunteer at Community Medical Center. In order to be considered for our program, the applicant must be at least 14 years of age. As standard procedure, a recommendation form will need to be completed by your daughter/son guidance counselor. This form will be sent by the Volunteer Department.

The law states that when a student is under 18, parental permission must be obtained before school records can be released. Please sign the form below so that we can request recommendation from your daughter/son guidance counselor. This form must be returned To the volunteer department along with the application.

If you have any questions, please feel free to contact us at 732-557-8000 at ext. 11256. Thank you for your cooperation.

Sincerely,

Gladys Zakar, CAVS
Coordinator
Volunteer Resource Center

To: Guidance Department

School

I, the undersigned, hereby authorize release of school records of the following student:

Student's Name _____

Year of graduation _____

Signed: _____

Parent/Guardian