Sebastian River Medical Center
Teen Volunteer Application

Name____

Address____

City____________________State______Zip_______E-mail Address__________________

Home Phone_______________Cell Phone________________Date of Birth_____Age______

School____Grade____________________

Parent or Guardian Name_______________________________Relationship_______________

Home Telephone____________Business Telephone__________Cell Telephone_____________

Address____

City__________________________________State_______________Zip____________

Emergency Contact Name__________________________Relation to Applicant______________

Telephone (day)_________________Telephone (evening)_______________Cell___________

Sebastian River Medical Center will not be responsible for the teenage volunteer before or after duty hours.

References

School reference (principal or teacher)

Name______________________________________Signature_____________________

Phone_________________________________Title_____________________________

Address________________________________City___________State_______Zip______

Other reference (do not use a relative)

Name______________________________________Signature_____________________

Phone_______________________How do you know the applicant?_____________________

Address________________________________City___________State______Zip______

Why do you want to be a volunteer at Sebastian River Medical Center?________________________________

____

What special skills/talents do you have that you can use as a volunteer?________________________________

____

Do you prefer to volunteer in a specific department or service area?______Yes ______No

If yes, where?____

What days/times are you available to volunteer?____

____

Do you have any allergies?________Yes ______No. If so, what are you allergic to (i.e., latex, peanuts, dairy products, etc.).____

Volunteer Confidentiality Commitment

I understand and agree that in the performance of my duties as a volunteer of Sebastian River Medical Center I must hold health information in confidence. Furthermore, I understand that intentional or involuntary violation of confidentiality may result in punitive action including termination and possible fine or imprisonment.

I also understand that even though I may have access to confidential records on the computer, I am expected to access only that information that I have a need to know and hold that information in strictest confidence.

I certify that I have read and understand this confidentiality statement. In accepting the terms of my volunteer service at Sebastian River Medical Center, I accept the responsibility of adhering to the above stated policy and other rules and regulations of Sebastian River Medical Center.

Print Name Volunteer:____ Date:______________

Volunteer signature:____Date:_____________

Print Name Parent/Guardian:_______________________________________Date:______________

Parent/Guardian signature:____Date:______________

Volunteer Acknowledgement

As a Sebastian River Medical Center Teen Volunteer, I agree to:

- Hold as absolutely confidential all information that I may obtain directly or indirectly concerning patients and staff. I will not seek to obtain confidential information.
- Be punctual and conscientious.
- Conduct myself with dignity, courtesy, and in consideration of others.
- Endeavor to make my work professional.
- Wear an approved uniform and maintain a professional appearance while on duty.
- Attend orientation(s) as required.
- Carry out assignments and seek the assistance of my supervisor/mentor when necessary.
- Take any problems, criticism or suggestions to the Volunteer Coordinator.
- Adhere to the Volunteer Service Department's sign in and out procedures.
- Commit to a minimum of 50 volunteer hours.

I understand that the Volunteer Coordinator reserves the right to terminate my volunteer status as a result of:

- Failure to comply with Sebastian River Medical Center policies and procedures
- Unsatisfactory attendance, attitude, work or appearance
- Other circumstances which, in the judgment of the Department Director and/or Volunteer Coordinator, would make my continued service as a teen volunteer contrary to the best interest of Sebastian River Medical Center

I have read each of the above conditions and I agree to be bound by them.

______________________________	______________________
Teen volunteer print name	Date
______________________________	______________________
Teen volunteer signature	Date