VolunTEEN Application

| RMH Auxiliary 10 Angeline St N Lindsay, ON K9V 4M 705-324-6111 ext. 4386 | | Date of Applicati Date of Interview Orientation: | on: /: | CE USE ONLY Membership T-shirt: 1 st Health screening: Time: |
|---|------------------------|--|------------|---|
| | First | City: | | stal Code: |
| Are you between the ag School & Grade <u>:</u> | | | | |
| Do you have any limita extra curricular activitie | tions which may a tes) | affect your Volun | TEEN place | |
| Experience: | | | | |
| Work: | | | | |
| Volunteer Work: | | | | |
| Skills/Interests: | | | | |
| References: Please list 2 adults (exc who can attest to your c counselor, clergy, empl | haracter, skills ar | · · · · · · · · · · · · · · · · · · · | • | - |
| 1. Name: | Relationsh | ip: | | |
| Phone: | Daytime: | | Evening: | |
| 2. Name: | Relationsh | ip: | | |
| Phone: | Daytime: | | Evening: | |
| Volunteer Service oppo | rtunities: (please | circle area (s) of | interest) | |
| | Patient Care (i.e. | Complex Care Pr | ogram) | |

Café

Gift Shop

Information Desk

In essay style answer the following: (Please feel free to use another page)

- a) How you heard about our program.
- b) Why you are interested in volunteer work in a health care setting.
- c) Explain how your volunteer service can benefit Ross Memorial Hospital.

Please read the following carefully before signing this application.

Teen Commitment/Agreement

I agree to provide regular and dependable volunteer service, and will adhere to the policies of the RMH and the RMH Auxiliary, with particular attention to the Hospital Policy on Confidentiality. I understand that information on my application will be verified by RMH Auxiliary. I authorize RMH Auxiliary to contact and receive information from the references listed. <u>I understand this is an application for and not a commitment or promise of volunteer opportunity.</u> I understand that any misrepresentation made by me in connection with this application will be cause for my immediate rejection as an applicant for a volunteer position with RMH Auxiliary or my termination as a volunteer.

Signature: Date:

Parent/Guardian Agreement (complete for students under 18 years)

RMH Auxiliary reserves the right to dismiss your daughter/son's services as a VolunTEEN if the action is in the interests of the Auxiliary and her/him. Dismissal could result from: failure to comply with Auxiliary policies and procedures, inappropriate personal conduct, attitude, appearance or absenteeism. If my daughter/son is accepted into the Auxiliary VolunTEEN program, **I give my consent** for RMH to administer and monitor a 2 step Tuberculin skin test and conduct blood tests to confirm immunity for chicken pox, mumps, red measles and german measles if necessary.

| My daughter/son | _has my permission to serve as a Ross |
|--|---------------------------------------|
| Memorial Hospital Auxiliary VolunTEEN. | |

| Parent signature: | Date: |
|-------------------------------|--------|
| In case of emergency, notify: | |
| Relationship: | Phone: |