REGIONAL MEDICAL CENTER BAYONET POINT

Teen Volunteer Application

14000 Fivay Road, Hudson, FL 34667 **(For information call: 727-869-5522)**

Volunteer #:_____ **Interview Date:**_____ **Orientation Date:**_____

Uniform:

Type: ☐ Men's Smock ☐ Ladies Smock ☐ Cobbler

Size: ☐ S ☐ M ☐ L ☐ XL ☐ XXL ☐ XXXL

APPLICANT: Please Complete Below and Back Side of this Form

Name:_____
Last Name First Name Middle Initial

Address:_____
Street Address City State Zip Code

Home Phone:_____ **Cell Phone:**_____ **Email:**_____

Date of Birth:_____ **SS#:**_____ **Male or Female** (circle one)

In case of emergency contact:_____
Name Relationship Phone No.

Hours Available:

Morning	**Afternoon**	**Evening**
☐ 8am – 12pm	☐ 12pm – 4pm	☐ 4pm – 8pm

Day/Days Available:

☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat

Assignments:_____

Special Skills:_____

Prior Volunteer or Work Experience:_____

Why do you want to be a volunteer?_____

Please list any physical limitations:_____

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If you have epilepsy, diabetes, allergies, heart condition, etc., and/or are taking special medication for any condition, it is important that you advise us so that in the event of an emergency resulting from your illness, medical personnel can provide proper treatment. This information will at all times remain confidential, except where it affects your ability to receive medical attention.

Family Physician:_____ Telephone:_____

Address:_____
Street Address City State Zip Code

School presently attending:_____ Grade:_____

Name of school counselor:_____ Telephone:_____

School counselor recommendation:_____

_____

_____

_____

Date:_____ School Counselor Signature:_____

I hereby certify that the information I have written on this application is true and correct and I understand that upon registering for teenage volunteer service at Regional Medical Center Bayonet Point, I will be subject to interview and placement by the Volunteer manager in a position mutually agreed upon by both parties. I agree to adhere to all the rules and regulations of Regional Medical Center Bayonet Point.

X_____
Signature of applicant

I hereby consent to my son/daughter's participation in the Teenage Volunteer program at Regional Medical Center Bayonet Point for the day/days and hours stated. I authorize the release of pertinent medical information in case of a medical emergency. I understand that in case of an accident that the hospital will bill all insurance providers as applicable and I hereby release Regional Medical Center Bayonet Point for liability due to injury and/or illness of my child as a result of their teenage volunteer service at this Medical Center.

X_____
Signature of Parent/Legal Guardian