



Magee-Womens Hospital

of University of Pittsburgh Medical Center

Department of Volunteer Services

JUNIOR VOLUNTEER APPLICATION

DATE: _____

NAME: _____

PHONE: _____

Home

ADDRESS: _____

Cell

Street

City

State

Zip Code

E-MAIL ADDRESS: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

Month/Day/Year

(for ID badging purposes)

Parent Name

PHONE: _____

Home

Cell

Parent Name

PHONE: _____

Home

Cell

CALL IN EMERGENCY:

Name

Relationship

Address

Contact's Home Phone

City, State, Zip

Contact's Work Phone

Contact's Cell Phone

PLEASE LIST ANY RELATIVES WORKING AT MAGEE: _____

SCHOOL AND PRESENT GRADE: _____

LAST DAY OF SCHOOL THIS YEAR: _____

FUTURE CAREER INTERESTS: _____

CLUBS AND ORGANIZATIONS: _____

HOBBIES AND SPECIAL INTERESTS: _____

Please include special talents and skills

VOLUNTEER WORK PREFERENCE

Type of Work Preferred

Day(s) and time(s) you would like to volunteer

MIN 4 HOURS PER DAY AND MAX 8 HOURS PER WEEK

ALL JUNIOR VOLUNTEERS ARE REQUIRED TO VOLUNTEER FOR A MINIMUM OF 20 HOURS IN THE SUMMER JUNIOR VOLUNTEER PROGRAM.

Why did you choose Magee? _____

What do you hope to gain from your volunteer experience? _____

REFERENCES

Please list teachers, counselors or employers, not a family member or personal friend. IN ORDER FOR US TO PROCESS YOUR APPLICATION, PLEASE PROVIDE US WITH ACCURATE AND COMPLETE REFERENCE INFORMATION. Please write clearly.

1.	(Mr.)(Ms.) _____ Name	_____
	_____	Telephone
	School or Organization Name	_____
	_____	Fax
	Street Address	_____
	_____	Relationship
	City State Zip Code	_____
2.	(Mr.)(Ms.) _____ Name	_____
	_____	Telephone
	School or Organization Name	_____
	_____	Fax
	Street Address	_____
	_____	Relationship
	City State Zip Code	_____

I wish to become a volunteer at Magee-Womens Hospital with an understanding of the following:

- I will accept supervision graciously.
- I will conduct myself with dignity.
- I will consider all information, which I may see or hear as a volunteer, confidential.
- I will take problems, criticisms or suggestions to the Director of Volunteer Services.
- I will endeavor to do my best in my work at the Hospital.

I hereby acknowledge that I have read the above statement and understand the same.

Signature of Applicant

Date



Magee-Womens Hospital

of University of Pittsburgh Medical Center

PARENTAL PERMISSION FORM

I hereby give permission for my daughter/son _____ to volunteer at Magee-Womens Hospital.

I understand that work to be done at Magee-Womens Hospital will include only non-professional duties. I understand my daughter/son will be working as a volunteer.

I certify she/he is in good health and has no physical limitations.

Please share any information with the Volunteer Services Department that would be helpful for us to know and would enhance your daughter's/son's success in the Junior Volunteer Program. For example: special medications, allergies, limitations, diabetes, etc.

ALL OF THIS INFORMATION WILL BE KEPT IN STRICT CONFIDENCE.

-OVER-

**Please turn sheet over for
Parent Signature**

I verify that she/he has received the Measles and Rubella (German Measles) vaccine: YES NO

Date Received _____

My daughter/son has had the Chicken Pox: YES NO

My daughter/son has received a Tuberculosis Mantoux Skin test in the past 6 months and she/he will bring the appropriate documentation to the Volunteer Office: YES NO

My daughter/son has my permission to receive a Tuberculosis Mantoux Skin test to be read by the Health Services Nurse 48 to 72 hours after the skin test is administered: YES NO

Please note: All volunteers must receive a Tuberculosis mantoux skin test before she/he starts. This information must be completed before your daughter/son can begin volunteering. Thank you for your cooperation and please call (412) 641-4185 if you have any questions.

PARENT/GUARDIAN NAME – PLEASE PRINT

SIGNATURE OF PARENT/GUARDIAN

HOME TELEPHONE

BUSINESS TELEPHONE

DATE