

Application for Student Volunteer Service

Minimum age 16. Mail completed form to: Volunteer Services,
St. Catherine Hospital, 4321 Fir Street, East Chicago, IN 46312

Please print clearly

Today's Date: _____

Name: _____
Last First Middle

Address: _____
Street City State Zip Code

Phone Number: _____ Cell Phone # _____

E-mail: _____ U.S. Citizen Yes No

Service area of interest:

1. _____
2. _____
3. _____

Availability:

Please circle:

Day: S M T W TH F SA

Time: Mornings Afternoons Evenings

School: _____ Grade _____

Clubs and Activities: _____

Awards, Honors, Special Accomplishments: _____

Volunteer Experience: _____

Skills: _____

References:

Name: _____

Address: _____

Phone: _____

Name: _____

Address: _____

Phone: _____

Emergency Contact:

Name: _____

Address: _____

Phone: _____

Cell #: _____

Who or what encouraged you to volunteer? _____

Are you volunteering because of school requirements? Yes No

If yes, how many hours? _____

Please read the foregoing conditions of volunteerism. Your signature indicates that you agree to comply with the terms and conditions within:

1. By signing this application, I verify that the information contained in this application is correct to the best of my knowledge. False information may be grounds for rejection of my application or termination of service. Submission of this application does not automatically insure placement.
2. If placed, I will be required to have a health assessment and my continued volunteerism will be subject to my ability to satisfactorily perform the duties and responsibilities of my position.
3. Our selection is not based on race, creed, color, religion, national origin, age, sex, physical or mental disability.

I have read the foregoing Conditions of Volunteerism and I agree to comply with the terms and conditions therein:

Parental Consent:

I hereby give permission for my daughter/son to volunteer and certify that all information in this application is correct. I give permission for my child to have a PPD test for tuberculosis and urine drug screen. I understand that my child cannot begin his/her service until the results of these tests have been confirmed.

Parent/Guardian Signature

Date

Student Commitment:

Community Healthcare System is dedicated to providing quality health services, providing compassionate care of body, mind and spirit, and delivering superior service to our patients, families and visitors.

I also agree to respect the dignity and rights of each individual and maintain all information in the strictest of confidence. I understand that violations of any policy of the Community Healthcare System may result in the immediate dismissal from the Volunteer Program.

I understand that volunteerism is subject to conditions of the Drug Free Workplace Act of 1988.

Student Signature

Date

New Volunteer Checklist

(Official Use Only)

Service Description: _____

Date of Placement: _____

- Date of Birth _____
- Form of Identification _____
- 1st TB _____
- 2nd TB _____
- Identification Badge _____
- Orientation _____
- Handbook _____
- Uniform _____
- Schedule _____
- Auxiliary Application _____
- Confidentiality Statement _____
- Code of Conduct / Corporate Compliance _____

Comments:
