



Teen Volunteer Services Application (Ages 16-17)

Thank you for your interest in becoming a Teen Volunteer. Please make an appointment with the Volunteer Coordinator/Director at 847-360-4228 or vsavolunteer@amhealthsystems.com. Bring your application, signed by you and your parent or guardian, along with a letter of recommendation to the Volunteer Services Department on the day of your appointment. A TB test, drug screen, and a copy of your immunization records is a mandatory requirement before volunteer placement can begin.

Please Print

First Name: _____ Middle _____ Last _____

Parents or Guardian name(s) _____

Address: _____ Email: _____

City: _____ State: _____ Zip: _____

Phone: _____ Secondary Phone: _____

Date of Birth: _____ Age: _____

Referred by: _____

School Activities: _____

Check skills and training: Typing _____ Filling _____ Other: _____

EMERGENCY INFORMATION:

Emergency Contact name: _____

Relationship to you: _____ Phone: _____

QUESTIONNAIRE:

Do you have any physical conditions, which may limit your activities/abilities to perform any of the various volunteer jobs? Yes: _____ No: _____

If yes, please explain _____

Special interests/hobbies/skills: _____

Volunteer shift are typically from 8-noon, noon-4pm or 3-7pm but can be flexible.



Do you have any friends, relatives, acquaintances employed by or volunteering at the hospital?

If yes, please list: Yes _____ No _____

Name _____ Position _____ Relationship: _____

Briefly explain why you want to join our Teen Volunteer Program:

PARENTAL/GUARDIAN SIGNATURE

I hereby permit my son/daughter/charge _____ to participate in the Teen Volunteer Program. I also give permission for a drug test to be completed on my son/daughter/charge for participation in this program and understand that I will be informed if the test is positive. I further release the hospital from any legal or other responsibilities for any injuries, act, or incidents involving the volunteer.

Parent/Guardian Signature _____ Date _____

TEEN VOLUNTEER APPLICATION SIGNATURE

I hereby submit my application and letter of reference for the Teen Volunteer Program. I agree to a drug test for participation in this program and understand that a positive test result will be provided to my parent/guardian. I understand that the Volunteer Services Director makes all regular assignments, based on personal interview and the interests of each prospective teen volunteer. I agree to abide by the policies and procedures of the Volunteer Services Department.

Confidentiality Agreement:

I understand and agree that, in the performance of my duties as a teen volunteer, I must hold patient/medical information in confidence. Information should not be discussed with any individuals including co-workers, other volunteers or family. I also understand that any violation of patient confidentiality will result in termination from the volunteer program.

Teen Signature _____ Date: _____

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