UNIONTOWN HOSPITAL
*Making a Healthy Difference in the Lives We Touch*

**Volunteer Services (724) 430-5671**
**JUNIOR VOLUNTEER APPLICATION**
***Minimum age for junior volunteers is 14 years.***

**Please Print:**

**Name:** _____ **Date:** _____

**Father's Name:** _____ **Mother's Name:** _____

**Address:** _____

**City:** _____ **State:** _____ **Zip:** _____

**Phone: (  )** _____ **Birthdate:** _____

**Email Contact:** _____ **May we contact you by email? Yes No**

**Current School You Attend:** _____

**High School You Will Graduate From:** _____

**Current Grade:** _____ **Year Of Graduation (High School):**

**Emergency Contact Person:** _____

**(  )** _____ _____
*Phone* *Relationship to You (Aunt, Grandmother, etc.)*

**List any limitation or restriction that affects your physical or mental ability to volunteer:**

_____

**Work Experience:** _____

**Volunteer Experience:** _____

**Are you considering health care career? If so, in what field:** _____

**Please specify if you want to work in a certain hospital department:** _____

_____

**List activities in which you participate: (hobbies, sports, school clubs, community organizations, church groups, etc.)**

_____

_____

**Do you have any relatives currently working at this hospital? If so, please list:**

**Name:**_____ **Department:**

**Name:**_____ **Department:**

## PARENTAL PERMISSION

I hereby give permission for my son/daughter _____ to become a volunteer at Uniontown Hospital. I understand that volunteers provide a supplemental service that compliments the work of Uniontown Hospital staff, and in no way, is a replacement for staff. Also, that as members of the Junior Auxiliary, teens must volunteer a minimum of twice a month and give at least 50 hours of service within a twelve-month period. I have verified that the information on this application is correct. I will do my best to ensure that my daughter/son fulfills the responsibilities outlined in the Volunteer Manual and presented at the Orientation Session.

_____ **DATE:** _____

***Signature of Parent or Guardian***

***The Uniontown Hospital Volunteer Program does not discriminate on the basis of race, color, sex, age, religious creed, national origin, ancestry or disability in the selection and placement or in the provision of services.***

**Please complete this application and return to**

*Uniontown Hospital Volunteer Services*
*500 West Berkeley Street, Uniontown, PA 15401*

*By FAX: 724.430.8631*

*Or By Email: flasher@utwn.org*

**THE UNIONTOWN HOSPITAL**
**VOLUNTEER REFERENCE LIST**

VOLUNTEER NAME:_____

Prior to beginning your assignment, you must have two positive references from adults who know you well enough to recommend you as a volunteer. Such persons may not be related to you, and should be a teacher, guidance counselor, advisor, coach, minister, scout leader or youth group leader.

Please list the names of three adults below. The Volunteer Office will mail a reference form to each person listed below.

**Be sure to provide a complete mailing address and the correct spelling of the names.**

**PLEASE PRINT**

**Reference #1**: Name_____

Position_____

Address_____

_____

Daytime Phone_____

**Reference #2**: Name_____

Position_____

Address_____

_____

Daytime Phone

**Reference #3**: Name_____

Position_____

Address_____

_____

Daytime Phone_____

**Return this completed form to the Volunteer Office.**