



Date: \_\_\_\_\_

**STUDENT VOLUNTEER APPLICATION**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
E-Mail \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Current year of High School \_\_\_\_\_  
Mo./Date/Yr.

**Parent/Guardian:**

Name: \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ Work Phone \_\_\_\_\_  
City/State/Zip \_\_\_\_\_

**Emergency Information: (If different from parent/guardian)**

In case of emergency, please notify: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_

**Education:**

Name of School \_\_\_\_\_ City/Town \_\_\_\_\_  
Grade \_\_\_\_\_ Guidance Counselor \_\_\_\_\_  
Extra curricular activities \_\_\_\_\_

Is volunteering a school or religious requirement? Yes \_\_\_\_\_ No \_\_\_\_\_ Both \_\_\_\_\_  
If yes, please state hour's required \_\_\_\_\_

If no, why are you interested in volunteering? \_\_\_\_\_  
\_\_\_\_\_

What other language do you speak? \_\_\_\_\_

**Volunteer Preferences:**

Patient care services Yes \_\_\_\_\_ No \_\_\_\_\_  
Office Services Yes \_\_\_\_\_ No \_\_\_\_\_

***References: (Guidance Counselor to fill out the Sponsor Evaluation form and return it by mail in a school envelope)***

**Availability:** Please note hours available in appropriate spaces.

	Sunday	Monday	Tuesday	Wednes	Thurs.	Friday	Sat.
Time Available							

(Actual commitment time will be determined during interview with the Coordinator of Volunteer Services)

**I agree to abide by the requirements and regulations of Palisades Medical Center and the service to which I am assigned. I will serve a minimum of sixty hours (60) after participating in required training. Letters of recommendation or acknowledgement of Volunteer Service will not be issued prior to completion of 60 hours of volunteer service.**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Parent's Agreement:**

My son/daughter \_\_\_\_\_ is **15 years of age** or older and has my permission to volunteer at Palisades Medical Center. I realize the responsibilities of this position and will cooperate to help him/her to comply.

In the event that my child becomes ill or injured while volunteering and I cannot be reached, I hereby give my consent to have him/her treated by a staff physician.

Parent's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Please Note: Completion of this application does not guarantee a volunteer position with the organization.**

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**Exit Interview**

: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Deposit returned: \_\_\_\_\_

Volunteer Signature

**JUNIOR VOLUNTEER SPONSOR EVALUATION**

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Recommendation:

I recommend (do not recommend) this student for volunteer service.

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

School Attendance Record: (Please check)

Excellent ( )    Good ( )    Fair ( )    Poor ( )

School Academic Record:

Excellent ( )    Good ( )    Fair ( )    Poor ( )

<u>Characteristics:</u>	Good	Average	Poor
Leadership	( )	( )	( )
Ability to follow instructions	( )	( )	( )
Cooperation with authority	( )	( )	( )
Appearance	( )	( )	( )

\_\_\_\_\_  
(Counselor/Teacher) Signature

Date: \_\_\_\_\_

**Please seal in school envelope and return to:**

Denise Whitley  
Volunteer Services Department  
Palisades Medical Center  
7600 River Road  
North Bergen, NJ 07047  
Phone 201 854-5011