Palisades Medical Center Foundation

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_____

<u>References:</u> (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.*

I authorize Palisades Medical Center and the PMC Foundation to use my Son/ Daughter's name and/or photograph in marketing materials to help promote Volunteer Services at PMC.

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.

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 ( )

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

_____Date: _____
(Counselor/Teacher) Signature

Please seal in school envelope and return by mail to:

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

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