



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 dose 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 ()

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

_____ Date: _____

(Counselor/Teacher) Signature

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