

CHESTNUT HILL
HOSPITAL

Teen Volunteer Application

Name: _____ Date: _____
(Last) (First) (Middle)

Preferred or Nickname: _____

Address: _____
(Street) (City) (State) (Zip)

Home Phone: _____ Mobile Phone Number: _____
Please circle preferred phone number to reach you by during the day.

Driver's License Number: _____ Photocopy: Yes No

E-mail Address: _____ Date of Birth: _____

Emergency Contact: _____
(Name) (Relationship)

Experience:

Present Employer _____ Position _____

Previous Employer _____ Position _____

Current Volunteer Experience – Organization Name _____ Position _____

Previous Volunteer Experience – Organization Name _____

Special Interests or Skills:

Why do you want to volunteer at Chestnut Hill Hospital?

What type of volunteer service most interest you?

What days and hours are you available: Check all that apply.

- Monday AM Tuesday AM Wednesday AM Thursday AM Friday AM Saturday AM Sunday AM
 Monday PM Tuesday PM Wednesday PM Thursday PM Friday PM Saturday PM Sunday PM

What date are you available to begin volunteer service? _____

Do you have any physical conditions, which may limit your activities or abilities to perform any of the various volunteer jobs?
 Yes No If "yes" please explain below:

Education:

High School _____ (Graduation Year)

Other School _____ (Years Attending / Graduating Year)

Applicant Signature:

I hereby make application to the Teen Volunteer Program. I agree to a drug test for participation in this program. I understand that the Volunteer Services Director makes all regular assignments, based on a personal interview and evaluation of each prospective teen volunteer. I agree to abide by the policies and procedures of the Volunteer Services Department.

Teen Signature: _____ Date: _____

Parental / Guardian Signature:

I hereby permit my son / daughter / charge _____ to participate in the Teen Volunteer Program.
 (Print Teen Name)

I also give permission for a drug test to be completed on my son / daughter / charge for participation in this program. I further release the Hospital from any legal or other responsibilities for any injuries, act, or incidents involving the volunteer.

Parent / Guardian Signature: _____ Date: _____

Phone Number: _____

Human Resource Area

Referral Source:				
Date Received:	Interviewed by:	Interview Date:	Position Offered:	
Orientation Date:	Annual Review Date:	TB:	Med Form:	

If you have any questions or concerns regarding the Teen Volunteer Program, contact Eyi Acolatse, Human Resources at 215-248-8026.

Fax or scan completed application form to the attention of: Eyi Acolatse, Human Resources. Fax: 215-248-8072 or email address: Eyi_Acolatse@chs.net