

**TEENAGE VOLUNTEER APPLICATION**

REGIONAL HEALTHCARE, INC.

SPRING HILL REGIONAL HOSPITAL

DATE \_\_\_\_\_

ARE YOU DOING COMMUNITY SERVICE FOR A SCHOOL, CHURCH OR SCHOLARSHIP \_\_\_\_\_

CREDIT \_\_\_\_\_ COURT ORDERED \_\_\_\_\_

NAME (LAST) \_\_\_\_\_ FIRST \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY & ZIP \_\_\_\_\_

PHONE NUMBER \_\_\_\_\_ EMERGENCY # \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

SCHOOL ATTENDING \_\_\_\_\_ GRADE \_\_\_\_\_ G.P.A. \_\_\_\_\_

PREVIOUS WORK OR VOLUNTEER EXPERIENCE \_\_\_\_\_

HOBBIES, INTERESTS, CAREER PLANS \_\_\_\_\_

NAME OF PARENTS \_\_\_\_\_

HAVE YOU EVER BEEN CONVICTED OR HAD ADJUDICATION WITHHELD IN A CRIMINAL OFFENSE OR ARE THERE ANY CRIMINAL CHARGES NOW PENDING AGAINST YOU?

YES \_\_\_\_\_ NO \_\_\_\_\_ IF YES, EXPLAIN \_\_\_\_\_

WHAT PHYSICAL CONDITIONS SHOULD BE TAKEN INTO CONSIDERATION IN ARRANGING VOLUNTEER ASSIGNMENT FOR YOU? \_\_\_\_\_

DAYS AND HOURS AVAILABLE TO WORK \_\_\_\_\_

I give my teenager \_\_\_\_\_ permission to work as a TEENAGE VOLUNTEER at the above named hospital. Prior to working as a TAV, I give the hospital permission to do a P.P.D. Skin Test to eliminate the possibility of my child having TB. I understand that this test will be given FREE OF CHARGE. If results are not read in the specified instructions, he/she will NOT be able to continue working until the test is taken again. Also, I give my permission for him/her to work until 8:P.M. and will see to it they have transportation to and from work.

MOTHER'S SIGNATURE \_\_\_\_\_

FATHER'S SIGNATURE \_\_\_\_\_

\*\*\*\*\*

PLEASE DO NOT WRITE BELOW THIS LINE

INTERVIEW \_\_\_\_\_ ORIENTATION \_\_\_\_\_ STARTING DATE \_\_\_\_\_ SIGNED FORMS \_\_\_\_\_

UNIFORMS \_\_\_\_\_ NAME TAG \_\_\_\_\_ DEPOSIT \_\_\_\_\_ PPD \_\_\_\_\_ HANBOOK \_\_\_\_\_

PLACEMENT \_\_\_\_\_ RESIGNATION DATE \_\_\_\_\_

REASON \_\_\_\_\_

DEPOSIT REFUND REQUESTED (DATE) \_\_\_\_\_



**AUTHORIZATION FOR BACKGROUND INQUIRY**

I authorize Hernando HMA, Inc., doing business as Hernando Healthcare, Brooksville Regional Hospital and Spring Hill Regional Hospital to conduct a background investigation on my child, \_\_\_\_\_.  
This investigation will include criminal history, driving history and any prior employment.

I understand that any information obtained may be used to evaluate my child's qualifications for becoming a Teenage Volunteer for which they are applying. I authorize, without reservation, any person or agency to furnish the above information to:

HERNANDO HEALTHCARE  
DIRECTOR OF VOLUNTEER SERVICES  
PO BOX 37  
BROOKSVILLE, FLORIDA 34605

\_\_\_\_\_ Date \_\_\_\_\_  
(Mother or Legal Guardian)  
AND

\_\_\_\_\_ Date \_\_\_\_\_  
(Father or Legal Guardian)

\_\_\_\_\_ Date \_\_\_\_\_  
(Notary's Signature)

Name of Applicant \_\_\_\_\_  
Birth date \_\_\_\_\_  
Social Security Number \_\_\_\_\_

Applicant's signature \_\_\_\_\_

1-18-2007

MEDICAL HISTORY AND AUTHORIZATION TO PARENT

As a potential volunteer at Spring Hill Regional Hospital, Inc., your teen is required by hospital policy to obtain a TB Skin Test prior to being placed into a volunteer position. Please be informed of the following test requirements:

Has he/she had a TB Skin Test in the last 6 months? \_\_\_\_\_ YES \_\_\_\_\_ No  
If yes, please send proof with his/her at the time of the interview.

If test is positive, we need a copy of his/her Chest X-Ray report stating that there are no abnormalities. If results are not read in the specified instructions he/she will NOT be able to continue working until the test is taken again.

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NAME \_\_\_\_\_

LIST ANY RESTRICTIONS OF APPLICANT \_\_\_\_\_

ALLERGIES TO DRUGS/FOODS \_\_\_\_\_

LAST TETANUS/TOXIN BOOSTER \_\_\_\_\_

PERTINENT MEDICAL HISTORY AND ANY SPECIAL MEDICATIONS TAKEN \_\_\_\_\_

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If your child has epilepsy, diabetes, allergies, heart condition, etc., and /or is taking special medications for any condition, it is important that you advise us so that in the event of an emergency, resulting from his/her illness, medical personnel can provide proper treatment. This information will at all times remain CONFIDENTIAL, Except where it affects his/her illness, medical personnel can provide proper treatment. Any and all job related injuries must be reported at time of incident, if not the hospital will not assume responsibility.

I GIVE PERMISSION FOR MY SON/DAUGHTER TO BECOME A MEMBER OF THE SPRING HILL REGIONAL HOSPITAL HEALTH CARE INC. VOLUNTEER PROGRAM. I GIVE MY PERMISSION FOR ANY NECESSARY TREATMENT TO BE GIVEN IN THE EVENT OF ILLNESS OR AN INJURY. YOU WILL BE NOTIFIED IF TREATMENT IS NECESSARY.

FATHER'S SIGNATURE \_\_\_\_\_ WITNESS \_\_\_\_\_ DATE \_\_\_\_\_

MOTHER'S SIGNATURE \_\_\_\_\_ WITNESS \_\_\_\_\_ DATE \_\_\_\_\_

LEGAL GUARDIAN \_\_\_\_\_ WITNESS \_\_\_\_\_ DATE \_\_\_\_\_

\*\*\*\* NEEDS TO BE NOTARIZED\*\*\*\*

RECOMMENDATIONS

APPLICANT: \_\_\_\_\_

Ask two teachers and your counselor for his/her recommendations and to sign this form.

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TEACHER RECOMMENDATION

I recommend the above named applicant to serve with a hospital setting as a Teen Volunteer. His/Her grade average is at least a "C."        YES        NO.

Comments, if any \_\_\_\_\_

TEACHER \_\_\_\_\_ TELEPHONE # \_\_\_\_\_  
(signature)

SCHOOL \_\_\_\_\_ DATE \_\_\_\_\_

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TEACHER RECOMMENDATION

I recommend the above name applicant to serve with a hospital setting as a Teen Volunteer. His/Her grade average is at least a "C."        YES        NO

Comments, if any \_\_\_\_\_

TEACHER \_\_\_\_\_ TELEPHONE # \_\_\_\_\_  
(signature)

SCHOOL \_\_\_\_\_ DATE \_\_\_\_\_

\*\*\*\*\*

GUIDANCE COUNSELOR RECOMMENDATION

I recommend the above named applicant to serve with a hospital setting as a Teen Volunteer. His/Her grade average is at least a "C."        YES        NO

Comments, if any \_\_\_\_\_

GUIDANCE COUNSELOR \_\_\_\_\_ TELEPHONE # \_\_\_\_\_  
(signature)

SCHOOL \_\_\_\_\_ DATE \_\_\_\_\_