Teen Volunteer Application Requirements and Information

Thank you for your interest in volunteering at Akron Children's Hospital. Volunteer Services offers a year round program for teens 16-18 years old (includes the summer following graduation). We enthusiastically welcome individuals of all backgrounds and abilities who are able to perform tasks independently with minimal supervision. Please note: volunteer placements are determined by program needs. Applicants must be in good general health, a non-smoker, and able to communicate well in English.

Commitment

- Volunteer weekly in a 3.5 hour shift (minimum 50 hours)
- Grade point average of 2.5 or higher

Process

- Complete and return the attached application
- Include a copy of most recent report card
- Include a copy of your immunizations
- Obtain two references from a counselor, teacher, or clergy
- You will be scheduled for an interview
- Attend a three hour orientation (orientation is offered twice a month)
- Purchase volunteer shirt ($15)

Applications and attachments can be returned the following ways:

Scan/e-mail: volunteers@chmca.org
Fax: 330-543-8008
U.S. Mail: Volunteer Services
Akron Children's Hospital
One Perkins Square
Akron, OH 44308-6176

Further details will be provided at the interview; however, if you have any questions, feel free to contact Volunteer Services at 330-543-3665. Thank you for your interest in Akron Children's Hospital.

PERSONAL INFORMATION				
Today's Date				
First Name	Middle Initial		Last Name	
Home Street Address				
City		State	Zip	
Cell Phone		Home Phone		
E-mail (required)				

EMERGENCY INFORMATION			
Emergency Contact		Relationship	
Cell Phone	Home Phone		Work Phone

EDUCATIONAL INFORMATION		
High School	Current Grade	Graduation Year

SCHOOL LEADERSHIP		
Name of Activity (Student Council, Athletics, Officer, Band, NHS, etc.)	Position Held	Grades Participated (9, 10, 11, 12)

VOLUNTEER EXPERIENCES			
Name and Address of Organization *(Please list your two most recent organizations)*	Position Held	Start Date	End Date

APPLICATION ESSAY

Type a 150-200 word essay describing how volunteering at Akron Children's Hospital would impact your life and why we should select you as a volunteer. Applicants will be judged on originality, punctuation, and grammar. Successful essays will incorporate your motivation for volunteering as well as a desire to meet new people, give back to the community, and help the patients and their families.

VOLUNTEER ASSIGNMENTS

Indicate the day(s) of the week you are available to volunteer as well as the starting shift schedule you would prefer. If you are flexible in the days of the week and starting time, please place a check in any of the boxes based on your availability. This information will help us determine the position openings that may be of interest to you when you meet with the Volunteer Recruiter.

Volunteer Shift Start Times	Monday	Tuesday	Wednesday	Thursday	Friday
9 a.m.-12:30 p.m.					
12:30 p.m.-4 p.m.					

REFERENCES

Please provide two references – a teacher, counselor, or clergy. Family members will not be accepted.

Name	Phone	E-mail	Relationship

STATEMENT OF COMMITMENT

I hereby affirm that the information provided on this application is true and complete. I understand that any false or misleading representations or omissions may disqualify me from further consideration for volunteer service and may result in discharge even if discovered at a later date.

I authorize Akron Children's Hospital to verify any information I have provided. I hereby authorize persons from any schools, companies, or organizations, to include my references, named in this application to provide information about me contained in their records, and I release all such persons from liability regarding the provision of or use of such information.

I understand there are certain training requirements that must be fulfilled, and performance standards that must be maintained in order to volunteer at Akron Children's Hospital.

Finally, as an Akron Children's Hospital volunteer, I will:

- Agree to volunteer for a minimum of 50 hours
- Notify Volunteer Services any time I am unavailable to volunteer for my assignment
- Decline to perform any task for which I feel I have not been adequately trained or which would put me or others at risk
- Respect patient, family, and staff confidentiality; which I understand is both a patient right and the Hospital’s legal responsibility. Users of electronic, verbal, or written information systems have the same obligation regarding confidentiality.
- Abide by the rules and regulations of Akron Children’s Hospital and Volunteer Services
- Maintain the customer service standards in my interactions with patients, families, and staff
- Permit images of photos of me in my role as a volunteer to be used in public relations brochures or videos

____ ____________________

Volunteer Signature Date

Volunteers under the age of 18 or 18 years of age and still in high school need the signature of a parent or guardian. As the parent or guardian of the above prospective minor volunteer, I support and recommend him/her in this opportunity. Also, I have read the statement of commitment and my teenager,

____, born ____________ has my permission to become a volunteer at Akron Children's Hospital.

I understand documentation of two MMR’s is necessary.

An initial tuberculosis skin test as well as an annual flu vaccine are also required for volunteering; therefore, I give permission for my child to have this test and vaccine completed at Akron Children’s Hospital. I understand that there is no charge for this service.

____ ______________________

Parent/Guardian Printed Name Phone

____ ____________________

Parent/Guardian Signature Date

AKRON CHILDREN'S HOSPITAL

AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR
(Complete if under 18 years of age)

I (We), ______________________________ the parent(s)/legal guardian of

______________________________ , a minor, do hereby authorize Akron Children's Hospital to consent to any diagnostic, medical, surgical treatment of hospital care which is determined necessary by a licensed physician on the medical staff of Akron Children's Hospital. This authorization is valid when such diagnostics, treatment or care is considered by the physician or surgeon to be reasonably necessary to preserve the life of, or prevent serious impairment to, the health of the teen volunteer and the minor's parent/legal guardian is not immediately available to consent to such treatment.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required to provide specific consent to act in situations described above until such time as a parent or legal guardian is available to act on behalf of the teen.

This authorization will remain in effect until the minor's eighteenth birthday, unless revoked in writing and presented to the Volunteer Services Department of Akron Children's Hospital.

______________________________ ______________________
Parent/Legal Guardian Signature Date

____
Minor's Date of Birth

FOR OFFICIAL USE ONLY	
Date Received	Received by
Meeting With	Appointment Day and Time
Volunteer Assignment	Assignment Location
Assignment Day	Assignment Time
Orientation Date	Start Date

___*HIPAA/Confidentiality Statement*
___*TB Test*
___*Flu Shot*
___*Background Check*
___*Demographic Information*

___*ID Badge Issued*
___*Sign–in and out*
___*Attendance Tracking Report Procedures*
___*Entered VsysOne*

Teen Volunteer Reference Form

Reference Permission:

I give my permission to release any and all information below regarding my teen.

_______________________________________ _______________________________________
Parent's Printed Name Teen's Printed Name

_______________________________________ _______________________________________
Parent or Guardian Signature Date

Instructions: This form should be completed by a **counselor**, **clergy member** **or** **teacher** you have known for at least one year. Upon completion, please have your reference mail, fax, or scan and e-mail this form to:

Mail: Volunteer Services
Akron Children's Hospital
One Perkins Square
Akron, Ohio 44308

Fax: 330-543-8008
E-mail: volunteers@chmca.org

The above individual has applied with Akron Children's Hospital to serve as a teen volunteer and is providing you as their reference. Students accepted into this program should be punctual, reliable, and have a sincere interest in volunteering. Your assistance will be helpful in our evaluation process for volunteer placement. Any information you give will be held in strict confidence. **Please do not return this form to the student.**

Please check the appropriate box in each category:

Category	Excellent	Good	Adequate	Weak
Personal Appearance				
Character				
Maturity				
Emotional Stability				
Interpersonal Skills				
Attendance/Punctuality				
Motivation/Work Ethic				
Communication Skills				
Integrity				
Leadership Skills				

How long have you known the applicant? ________________________

Please provide a personal statement explaining your knowledge of the applicant and why you believe he or she would or would not be successful as a volunteer. Please feel free to use the back of this form for additional space.

____

____

Name of counselor/clergy member/teacher ____

Name of school/church____ Phone ___________________________

Signature ____ Date ________/________/__________

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