



For Office Use Only

Date Application Received _____
Date Interviewed _____
PPD Scheduled _____
Orientation _____

Junior Volunteer Program

PERSONAL DATA:

NAME: _____ **PHONE:** _____

DATE OF BIRTH: _____

ADDRESS: _____
Street City Zip Code

2ND ADDRESS: _____
Street City Zip Code

E-MAIL ADDRESS: _____ @ _____

PREVIOUS EMPLOYMENT: _____

SPECIAL SKILLS/INTEREST: _____

PREFERRED AREA OF HOSPITAL FOR DUTY:

- | | |
|-----------------------------------|---------------------------------|
| _____ Information Desk | _____ Waiting Room Host/Hostess |
| _____ Clerical | _____ Gift Shop |
| _____ Radiology | _____ Pharmacy |
| _____ Purchasing | _____ Physical Therapy |
| _____ Hospitality | _____ Patient Care |
| _____ Emergency Department | _____ Other |
| _____ Special Activities/Projects | |

Have you been convicted of a crime and/or released from confinement following a conviction for any criminal offense?

_____Yes _____No (Arrest or charges that have been expunged need not be disclosed.)

If yes, give date, place and nature of each such charge on the reverse side of this application.

Are you presently charged with any violation of the law? _____Yes _____No
(If yes, please give date, place and nature of each such charge on the reverse side of this application.)

REFERENCES: (please list two that are at least 18 years of age and not family members)

Name: _____ Address: _____

Telephone Number: _____ Position _____
Number of Yrs Known: _____

Name: _____ Address: _____

Telephone Number: _____ Position _____
Number of Yrs Known: _____

IN CASE OF ILLNESS WHILE ON DUTY, WHO SHOULD BE NOTIFIED?

Print Name

Relationship

Phone Number

VOLUNTEER PLEDGE

As a volunteer, I promise faithful and regular service and to uphold the standards of the hospital at all times.

Signature

Date

Additional space for explanations if needed: _____

Promotional Release

I, _____, parent of _____, consent for my child to be photographed for news releases and/or website promotion. I understand that my child may also participate in interviews conducted for press releases and/or website promotion by Pasco Regional Medical Center's Marketing Coordinator. I also understand that no compensation is forthcoming or implied.

I may withdraw my permission at any time; however, I understand that a release may already be scheduled for publication and ready for print. In this instance, I understand that it may not be possible to retract those publications already in progress.

Parent's Name -Print/Sign

Junior Volunteer's Name -Print

Date

PASCO REGIONAL MEDICAL CENTER

JUNIOR VOLUNTEER CONSENT FOR TB SCREENING

A Junior Volunteer at Pasco Regional Medical Center is a student age 14-18 who agrees to serve in the Pasco Regional Medical Center Volunteer Program and who fulfills the requirements and obligations of this group.

I am interested in being a Junior Volunteer at Pasco Regional Medical Center.

NAME _____ DATE _____

DATE OF BIRTH _____ AGE _____ SCHOOL _____

GRADE LEVEL _____ GRADE POINT AVERAGE _____

PARENT'S NAME(S) _____

ADDRESS _____
(Street) (City) (Zip)

CLASS SPONSOR/GUIDANCE COUNSELOR _____ PHONE NO. _____

Health Requirement: Tuberculin skin test now and yearly. If a Volunteer has a positive reaction, a chest X-ray will be given now and on a yearly basis.

I give permission for my child, _____ to be tested for TB by the Employee Health Nurse at Pasco Regional Medical Center.

Signature of Parent or Guardian Date

Witnessed By: _____ Date: _____

.....
This section for Office Use Only

Date of Interview _____ By _____

Source of Referral _____

1st Day of Assignment _____
(Date) (Place)

T-shirt Size (adult) _____ T-shirt Received _____

TB Test Complete _____ X-ray (if needed) _____

Comments _____



Volunteer Reference

A combination of personal and professional references is preferred. References can be people you know from church, your friends, co-workers, supervisors you have worked with or people you know from community activities.

Please, no relatives.

I, _____, give my permission for the information requested below to be released to
(Volunteer Name)

the Volunteer Services Office at Pasco Regional Medical Center.

Reference Name (please print)

Date

To the Volunteer Applicant Reference:

Please complete and return this form **within 10 days** along with a personal letter of recommendation. Your responses will allow us to better assess the applicant's ability to fulfill the responsibilities involved in our volunteer program. All information is confidential. Thank you.

How long have you know this person and in what capacity?

In your opinion, do you feel this person would be reliable in attendance?

Would this person keep information confidential (especially patient information)?

Would this person be tactful in dealing with patients and the public?

Is this individual trustworthy?

Do you believe this person will complete their commitment of at least 40 hours?

Please feel free to provide any additional information that might be useful in evaluating the volunteer applicant.

Reference Name (please print)

Signature

Date

_____(____)____ - ____
Phone Number

Please return to:

Annetta Evans, Volunteer Coordinator
Pasco Regional Medical Center
13100 Fort King Road Dade City, FL 33525
Phone: 352-521-1195 Fax: 352-521-1196
Annetta.Evans@prmc.hma-corp.com



Volunteer Reference

A combination of personal and professional references is preferred. References can be people you know from church, your friends, co-workers, supervisors you have worked with or people you know from community activities.

Please, no relatives.

I, _____, give my permission for the information requested below to be released to
(Volunteer Name)

the Volunteer Services Office at Pasco Regional Medical Center.

Reference Name (please print)

Date

To the Volunteer Applicant Reference:

Please complete and return this form **within 10 days** along with a personal letter of recommendation. Your responses will allow us to better assess the applicant's ability to fulfill the responsibilities involved in our volunteer program. All information is confidential. Thank you.

How long have you know this person and in what capacity?

In your opinion, do you feel this person would be reliable in attendance?

Would this person keep information confidential (especially patient information)?

Would this person be tactful in dealing with patients and the public?

Is this individual trustworthy?

Do you believe this person will complete their commitment of at least 40 hours?

Please feel free to provide any additional information that might be useful in evaluating the volunteer applicant.

Reference Name (please print)

Signature

Date

_____(____)____ - ____
Phone Number

Please return to:

Annetta Evans, Volunteer Coordinator
Pasco Regional Medical Center
13100 Fort King Road Dade City, FL 33525
Phone: 352-521-1195 Fax: 352-521-1196
Annetta.Evans@prmc.hma-corp.com