Junior and College Application

Applicants must be 14 by the date of orientation. Volunteers serve Doctors Hospital of Augusta without salary, and work within the hospital under the supervision of specified personnel and the Volunteer Coordinator. Youth/College Volunteers are required to serve a minimum of six hours monthly. To be considered, the following must be completed and submitted to the Volunteer Manager.

q Application q Essay q Recommendation q Guardian Consent Form **for applicants under the age of 18*

q Drug Test Consent q Transcript q Three professional references **college applicants only*

Name:

What do you hope to gain from your volunteer experience? _____

_____

_____

Have you served in a health care setting before? _____ **No** _____**Yes** **If yes, describe the experience:**

_____

_____

_____

Are there any work conditions you must avoid/limitations to health?

_____

_____

Essay: Why should you be considered for the Doctors Hospital of Augusta Youth/College Volunteer Program? *Essay may be*

Advisor / Counselor / Instructor Recommendation

Please print clearly, or include additional comments on a separate piece of paper.
Be sure to include a copy of applicant's transcript

_____ is applying for participation in the Youth/College Volunteer Program at Doctors Hospital of Augusta. Below please find my comments in regards to the student's performance in the following disciplines:

Conduct:

Ability to Understand and Follow Directions:

Initiative:

Attendance:

Punctuality:

[redacted]

Parent/Guardian Consent Form

**Required for applicants under the age of 18*

I hereby permit my son/daughter, _____, to participate in the Youth/College Volunteer Program at Doctors Hospital of Augusta. I realize the responsibilities of the organization and will cooperate with my son/daughter to comply with the rules and regulations that have been adopted. I will assume responsibility for his/her transportation. I understand that as a Youth/College Volunteer, the applicant will be required to complete a minimum of six (6) hours of volunteer work monthly or be dismissed from the program.

Additionally, I will cooperate with my son/daughter to comply with the established hospital health standards. This includes granting my permission for the employee health nurse to administer a PPD skin test to screen for tuberculosis, submitting a copy of my son/daughter's immunization record to be reviewed by the employee health nurse, and consenting to my son/daughter taking any blood or urinalysis drug screen requested by the hospital. These measures are necessary to ensure the health and well-being of my child.

In the event of a medical emergency, I permit the physicians in the Emergency Department of Doctors Hospital of Augusta to treat my son/daughter.

Guardian Signature: _____ Date: _____

Applicant Signature: _____ Date: _____

Primary Care Physician: _____ Phone: _____

List any know medical conditions/medications: _____

_____

List any known allergies: _____

It is the policy of this organization to provide equal opportunity to persons regardless of race, religion, age, gender, disability or any other classification in accordance with federal, state, and local statutes, regulations and ordinances.