



TEEN VOLUNTEER APPLICATION

Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home/Cell Phone: _____ E-mail Address: _____

Are you age 18 or older? YES NO

What is your birth date?

Are you currently employed? YES NO

If yes, may we call you at work, if needed? YES NO

Company Name: _____ Company Phone: _____

Are you volunteering to fulfill a requirement? YES NO

If yes, for what organization and how many hours are required?

Level of education:

How did you hear about our volunteer program?

Why are you interested in volunteering at Rush Oak Park Hospital?

When are you available to volunteer? *

	Monday	Tuesday	Wednesday	Thursday	Friday
Mornings	_____	_____	_____	_____	_____
Afternoons	_____	_____	_____	_____	_____

*** Short-term volunteers fulfilling community service hours must agree to honor the “40 hours in 3 months” time commitment required to become a part of Rush Oak Park Hospital’s Volunteer Program.**

Have you ever been convicted of a criminal offense or have a conviction pending?

(A yes answer will not necessarily result in your disqualification)

YES NO

Are you a U.S. Citizen? YES NO

Are you legally authorized to work in the U.S.? YES NO

Over please...

Please list two **professional** (i.e. from school, church, etc.) references. **Do not** list friends or relatives.

References listed below will be contacted and interviewed before applicant is accepted into the volunteer program.

Name: _____
Relationship: _____
Home/Cell phone: _____ E-mail Address: _____

Name: _____
Relationship: _____
Home/Cell phone: _____ E-mail Address: _____

List any medical restrictions, allergies, or requirements that may affect your volunteer work:

In an emergency, please notify:

Physicians name:	Personal contact:
Address:	Name:
City/State/Zip:	Phone:
Phone/E-mail:	Relationship to you:

Teen Volunteers Only (under 18 years of age):
Please ask your parents/guardian to sign below:

I hereby authorize Rush Oak Park Hospital to contact the references listed and conduct a criminal background check on my child, if necessary. I also consent and authorize Rush Oak Park Hospital to administer any lawful testing which may be necessary to fulfill the minimum health requirements to become a volunteer.

Parent's Signature: _____ Date: _____
SS#: _____ Birth date (mm/dd/yy) _____
(Parents- if you do not want to include your SS# and/or birth date on this form, you will need to personally accompany your child to the Employee Health Services Department of the Hospital when they come in to get their initial TB test.)

Please fax or mail completed application to:

Rush Oak Park Hospital
c/o Volunteer Services
520 S. Maple Ave.
Oak Park, IL. 60304
Fax: 708-660-6811

Please note: Volunteers do not take the place of salaried staff at Rush Oak Park Hospital. Volunteer service is not intended in any way to lead to paid employment. Applying to the Volunteer Program does not automatically guarantee acceptance/admission into the program.