



**TEEN VOLUNTEER SERVICES  
APPLICATION**  
939 Caroline Street  
Port Angeles, WA 98362

Thank you for your interest in becoming a Volunteer. Please return your application, signed by you and your parent or guardian, along with a letter of recommendation to the Volunteer Services Department. Placements for the Volunteer Program begin June 2010. Volunteer Orientation is required and will be held [to be announced].

**PERSONAL INFORMATION**

First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_  
Parent or Guardian \_\_\_\_\_  
Address \_\_\_\_\_ E-mail \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Secondary Phone \_\_\_\_\_  
Date of birth \_\_\_\_\_ Last 4 digits Social Security No. \_\_\_\_\_

**EMERGENCY INFORMATION**

Emergency Contact name \_\_\_\_\_  
Relationship to you \_\_\_\_\_ Phone \_\_\_\_\_

**QUESTIONNAIRE**

Special interests/hobbies/skills: \_\_\_\_\_  
\_\_\_\_\_

Volunteer shift are from 9:00 a.m. – Noon. Noon – 3:00 p.m.

Please select the days you are available to volunteer:

Monday  Tuesday  Wednesday  Thursday  Friday

**EDUCATION/COMMUNITY INVOLVEMENT/WORK EXPERIENCE**

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Courses currently taking, school activities, clubs, honors, etc.

\_\_\_\_\_

Do you have plans to continue your education after high school? If yes, what course of study do you want to want to pursue? \_\_\_\_\_

\_\_\_\_\_

If known, what career do you hope to pursue as an adult?

\_\_\_\_\_

List any community affiliations (church, civic groups, etc.)

\_\_\_\_\_

Are you seeking volunteer work as a requirement for any of the above activities/groups? If yes,

Please explain: Yes [ ] No [ ]

\_\_\_\_\_

Have you ever volunteered in the past before (school, civic)? If yes, please explain:

Yes [ ] No [ ]

\_\_\_\_\_

How did you hear about our Volunteen Program?

\_\_\_\_\_

Do you have any friends, relatives, acquaintances employed by or volunteering at the hospital?

If yes, please list: Yes [ ] No [ ]

Name Position Relationship

\_\_\_\_\_

Briefly explain why you want to join our Teen Volunteer Program:

\_\_\_\_\_

**ACADEMIC REFERENCE (school counselor, principal or teacher)**

Please attach a letter to your application.

**SKILLS/INTERESTS**

\_\_\_ Typing

\_\_\_ Filing

\_\_\_ Computer Operations

\_\_\_ Audio Visual

Other/Miscellaneous/Please List

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PLEASE READ THE FOLLOWING BEFORE SIGNING:**

Your placement as a volunteer with Olympic Medical Center is dependent upon the acceptance by Volunteer Services and completion of the hospital health requirements along with the report from the Washington State Patrol request for criminal history information (Child/Adult Abuse Information Act RCW 43.43.830). Olympic Medical Center is required to run a check on all volunteers and employees.

I hereby declare that all the information I have given above is true to the best of my knowledge. I further understand that my volunteering is contingent upon checking of references furnished. I consent to and authorize the hospital and its personnel to request any information concerning work and personal references as indicated on this application for volunteering. I hereby release all parties and persons connected with any request for information from all claims, liabilities, and damages for whatever reason arising out of furnishing such related information.

I am aware that the participation in the Volunteer Program may have risk of injury or illness. I understand there is no compensation or insurance benefit provided to me in the event that become injured or ill in the course of my volunteering. I acknowledge and accept the risks inherent to the Volunteer Program and working in a healthcare setting, and with this knowledge in mind, agree to participate in the Volunteer Program.

I understand I will not be paid for my volunteer services. I also agree to abide by ALL volunteer and hospital program policies and procedures.

\_\_\_\_\_ I give my permission to be photographed and used for press releases  
Initials

***TEEN VOLUNTEER APPLICANT SIGNATURE***

Name \_\_\_\_\_ Date \_\_\_\_\_

Phone Number \_\_\_\_\_

***PARENTAL/GUARDIAN SIGNATURE***

I hereby permit my son/daughter/charge \_\_\_\_\_ to participate in the Volunteer Program. I further release the hospital from any legal or other responsibilities for any injuries, act, or incidents involving the Volunteer.

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

Telephone Numbers \_\_\_\_\_

**Please return signed application to:**

**Olympic Medical Center  
939 Caroline Street  
Port Angeles, WA 98382**

**If you have any questions, please contact Kathy Coombes, Volunteer Coordinator  
(360) 565-9110**

**OR**

**[kcoombes@olympicmedical.org](mailto:kcoombes@olympicmedical.org)**