

Dear Prospective Junior Volunteer,

Thank you for your interest in Stamford Hospital's Junior Volunteer Program. **To participate in this program you must be at least 14 years old.**

Please read carefully and complete the attached forms.

1. Please fill out the application yourself and mail it back to the Volunteer Office. Your parent or legal guardian should sign the permission slip.
2. Attach a typed 150-word essay, explaining why you want to volunteer and what qualities make you an exceptional candidate for Stamford Hospital's Junior Volunteer Program. **Your application will NOT be considered if an essay is not attached.**
3. Have the enclosed recommendation form filled out and mailed back in a separate envelope.
4. If selected you will be asked to provide documentation of immunizations. In addition, all volunteers are required to have had at least two TB test within the last two years. For those selected a TB test can be done by your provider or at the hospitals Employee Health Office.
5. All forms should be mailed to:

The Stamford Hospital
Volunteer Resources Department
P.O. Box 9317
Stamford, CT 06904-9317

Or Faxed to: (203) 276-6121

6. All volunteers are required to complete 50 hours of service. This can be completed during a school year or 25 hours for two summers, with a minimum of two (2) hours on a weekly schedule. This is required upon issuing any recommendations.

When all of your forms are completed and mailed in, you will be contacted to schedule an interview. If you have any questions about our program, please call the Volunteer Resources Department at 203-276-7358.

The Stamford Health System Junior Volunteer Application

Name: _____ Phone: _____ Date: _____

Street: _____ City: _____ State: _____ Zip: _____

Age: _____ Date of Birth: _____ E-Mail: _____

Parent(s)/Guardian(s) Name: _____ / _____

Parent(s)/Guardian(s) Business Phone(s): _____ / _____

Name of School: _____ Grade: _____

Guidance Counselor: _____

Please check one or more:

- Office Support
 Arts & Entertainment
 Patient Support
 Baking

How did you hear about us? _____

Special talent/language skill: _____

Identify the days and times you're available weekly:

Days:	Mon	Tue	Wed	Thurs	Fri
Time:					

Student's Signature: _____

Office Use Only

Starting Date: _____

Assignment: _____

(Day)

(Time)

(Place)

Comments: _____

**The Stamford Health System
Parent Permission**

To be completed by parent or legal guardian.

Name of parent /legal guardian: _____

Home Phone: _____ **Work:** _____

Family Doctor: _____ **Phone#:** _____

Does your son/daughter have any health concerns that you feel we should be aware of?

I grant permission for my son/daughter to be a volunteer at The Stamford Hospital. I verify the age given to be correct. I will accept the judgment of the Director of Volunteers concerning matters relating to my son/daughter as a volunteer.

Signature of parent/legal guardian

Date

Consent for Treatment

All minors (under the age of 18) must have on file Consent for Treatment Form. This is a preventable measure in case of illness or injury while on duty, and would be used only after reasonable attempts to reach the parent or guardian had been made.

In the event _____(name) required medical and/or surgical treatment while volunteering within The Stamford Health System, I, the undersigned, hereby give my consent for any medical and/or surgical treatment as the attending physician and/or surgeon deems necessary. This includes the use of anesthetics.

I have read the foregoing and understand it.

Signature of parent/legal guardian

Date

Student Volunteer Recommendation

Dear Teacher/Counselor:

The student listed below has applied to be a volunteer within The Stamford Health System. We require an honest evaluation of each applicant so that we may place him/her in an appropriate position. All of this information is strictly confidential. Thank you for your cooperation. If you have any questions, please contact us at **203-276-7358**.

Mail to: **The Stamford Hospital, Volunteer Services**
30 Shelburne Road
Stamford, CT 06902

Student Name: _____ **Phone#:** _____

School and Grade: _____

Please rate the following (Excellent/ Good/ Fair/ Poor):

Attendance: _____

Academic Standing: _____

Follows Directions: _____

Works Independently: _____

Handles Responsibility: _____

Are there any disciplinary problems that could affect the student's ability to volunteer?

Comments:

Signature Date Title

Print Name Telephone #

Health Reference

It is important for the volunteer, as well as the patients, that we have up-to-date records on the health of our volunteers. Please fill out the form below and return it to the above address.

Name of Student _____

Measles Vaccination _____
Date

Rubella Vaccination _____
Date

Mumps Vaccination _____
Date

Chicken Pox: _____
Date

Last TB test (PPD): _____
Date Results

**PPD tests are available for students accepted into the Junior Volunteer program.
Two PPDs are required of new volunteers, per CDC-recommended two-step method.**

I certify that _____ (name) is in good health and has no health condition that would prevent him/her from participating in The Stamford Hospital Junior Volunteer Program.

Signature of physician/nurse

Please mail this form to: The Stamford Hospital
Volunteer Services Department
Shelburne Road at West Broad Street
Stamford, CT 06902