PREMIER
Community HealthCare
YOUR HEALTH. OUR MISSION.

TEEN VOLUNTEER APPLICATION

Minimum age requirement 15
13 if accompanied by a parent/guardian

Name: _____
Last Name First Name Middle Initial

Address: _____
Street Address City/State Zip Code

Home Phone: _____ Cell Phone: _____

Email Address: _____ Preferred Method of Contact: _____

Date of Birth: _____ Male ☐ Female ☐

Emergency Contact: _____
Name Relationship Phone #

T-Shirt Size: (unisex) XS ☐ S ☐ M ☐ L ☐ XL ☐ XXL ☐ XXXL ☐

Preferred Shift: * ***Special event times will vary per event***
8am - 12pm ☐ 12pm - 4pm ☐

Preferred Days: Mon ☐ Tue ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐

Preferred Tasks: _____

_____

Do you have any physical limitations we need to be aware of to properly assign you to a work area?

_____

_____

Special Skills:

_____

_____

Computer applications: _____

Language Fluency: _____

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School presently attending: _____ Grade: _____

Name of School Counselor: _____ Telephone: _____

School counselor recommendation: _____

_____

_____

School counselor signature: _____ Date: _____

I understand that an investigation report may be made by a consumer reporting agency and/or law enforcement agency to include information as to my character, general reputation, personal characteristics, and mode of living, whichever may be applicable. If such an investigative report is made, I will have the right to make a written request for complete and accurate disclosure of additional information concerning the nature and scope of the investigation

_____ _____

Applicant Signature Date

Thank you for your interest. You will be contacted to set up an interview. If you have any questions before then, please feel free to contact **Lisa DeMello at (352)518-2000 x9032 or Ljdemello@HCNetwork.org**.

I hereby consent to my son/daughter's participation in the Teenage Volunteer program at Premier Community HealthCare Group for the day/days and hours stated. I authorize the release of pertinent medical information in case of emergency. I understand that in case of an accident that the medical facility will bill all insurance providers as applicable and I hereby release Premier Community HealthCare Group for liability due to injury and/or illness of my child due as a result of their teenage volunteer service at any Premier Community HealthCare clinic.

_____ _____

(For all participants under 18) Signature of Parent/Guardian Date

Internal Use Only

Volunteer #: _____ Interview Date: _____ Orientation Date: _____

Training Date: _____ Training Supervisor: _____