DOCTORS HOSPITAL

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.

❑ Application ❑ Essay ❑ Recommendation ❑ Guardian Consent Form **for applicants under the age of 18*
❑ Drug Test Consent ❑ Transcript ❑ Three professional references **college applicants only*

Name: _____ Date: _____
Address: _____ Email: _____
Date of Birth: _____ Age: _____
Cell Phone: _____ Shirt Size: ❑ S ❑ M ❑ L ❑ XL ❑ 2XL
Name on Badge: _____

School: _____ Grade/Year: _____
Year of Graduation: _____ Career Interest: _____
Honors/Organizations/Extracurricular/Volunteer Experience:

_____

References
Please choose someone other than a relative who can attest to character/dependability.

Name: _____ Phone: _____
Email: _____ Relationship: _____

I want to volunteer: ❑ Summers only ❑ Year Round ❑ Varies, depending on school schedule
I would like to volunteer in (list top three areas/departments of preference):
1. _____
2. _____
3. _____

Volunteer Availability: (Please circle the days and times you are available to work.)

☐ Sunday	☐ Monday	☐ Tuesday	☐ Wednesday	☐ Thursday	☐ Friday	☐ Saturday
☐ AM ☐ PM ☐ EVE	☐ AM ☐ PM ☐ EVE	☐ AM ☐ PM ☐ EVE	☐ AM ☐ PM ☐ EVE	☐ AM ☐ PM ☐ EVE	☐ AM ☐ PM ☐ EVE	☐ AM ☐ PM ☐ EVE

Were you referred by a volunteer? Who? _____

How did you hear about volunteering at Doctors Hospital of Augusta?
❑ Another Volunteer
❑ School
❑

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.

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 neatly handwritten below, or typed separately and included with application.*

Doctors Hospital of Augusta Volunteer Services
3651 Wheeler Road
Augusta, Georgia 30909
(706) 651-3590

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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:

Additional Comments:

I, _____,

❑ do recommend
❑ do not recommend
this individual for participation in the Youth/College Volunteer Program at Doctors Hospital of Augusta.

Signature: _____ Date: _____

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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: _____

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