OakBend Medical Center
1705 Jackson Street
Richmond, Texas 77469

Junior Volunteer Program Application

Personal Information	
Name:	**Date:**
Date of Birth:	**Age**
Home Address:	
City, State Zip:	
Phone:	**Email:**

Education		
SCHOOLS ATTENDED- Current School First		
School Name	Dates Attended	Location

Parent /Guardian Information		
Father's Name	**Address**	**Phone**
Mother's Name	**Address**	**Phone**
Guardian Name	**Address**	**Phone**

References

Please enter information below about the teachers who will be providing letter of recommendation information.			
Name	**Position/School**	**Phone**	**Email address**
Name	**Position/School**	**Phone**	**Email address**

Personal Information

Have you been a junior volunteer at OakBend Medical Center before? _____
If so, when and what department(s)?_____
_____

Have you ever done volunteer work previously?_____
If so, list when and responsibilities:_____
_____

Do you have any work experience? _____
If yes, please specify:_____
_____

Do you have any physical handicaps or limitations? _____
If yes, please specify: _____
_____

Approximate date of last physical examination: _____

Are you interested in health care? _____

How did you hear of OBMC's Junior Volunteer Program?
_____

Do you understand that you may not accept money for this volunteer service? _____

Do you promise to regard as confidential any information concerning patients, medical staff, and/or hospital personnel?
_____

Signature of Applicant _____ Date _____

NOTE: Any volunteer who violates guidelines set by OAKBEND MEDICAL CENTER, or who fails to show up for duty without notification will be terminated from the program.

JUNIOR VOLUNTEER CANDIDATE: If accepted, I agree to adhere to the policies and procedures of OakBend Medical Center. **If accepted, I understand that I must commit to volunteering a minimum of 36 hours AND the entire 7 weeks. Students will not be attending during the enitre week of July 4th.**

Junior Volunteer Candidate Signature _____
DATE: _____

PARENT/GUARDIAN: The above named student has my consent as parent/guardian to participate as a Junior Volunteer with OakBend Medical Center. I have read the above agreement as signed by my child and understand their obligation to the program if they are accepted into the Junior Volunteer Program. If accepted, I understand that he/she must commit to volunteering a minimum of 36 hours. Transportation to and from the hospital is my responsibility. Further, I understand that OakBend Medical Center is not responsible in case of an accident.

THE FOLLOWING INFORMATION IS TO BE COMPLETED BY THE PARENT/GUARDIAN OF APPLICANT:

I give my permission for my child to participate in the Junior Volunteer Program:

Parent/Guardian Signature _____ Date _____

REQUIRED TUBERCULOSIS SKIN TEST AND/OR CHEST X-RAY
REQUIRED COPY OF CURRENT VACCINATIONS

OakBend Medical Center requires all new employees and volunteers to be screened for tuberculosis (TB) and/or a chest x-ray and copy of current vaccinations. If the student has had a previous positive reaction to the skin test, a chest x-ray must be obtained in lieu of the skin test. Please obtain the skin test or chest x-ray from your local health department or personal physician. **I understand this requirement and will provide OAKBEND MEDICAL CENTER with a copy of the applicant's results by the requested date if they are accepted to the program.**

Parent/Guardian Signature_____ Date_____

For Office Use Only:
Rotation assigned _____
TB Info On File _____