

Summer Internship 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 the information below about the teachers who will be providing a 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 internship candidate who violates guidelines set by OAKBEND MEDICAL CENTER, or who fails to show up for duty without notification will be terminated from the program.

JR Summer Internship 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 6 weeks. Students will not be attending during the entire week of July 4th.**

Junior Summer Internship Candidate Signature _____
DATE: _____

PARENT/GUARDIAN: The above-named student has my consent as parent/guardian to participate in a JR Summer Internship Program with OakBend Medical Center. I have read the above agreement signed by my child and understand their obligation to the program if they are accepted into the Summer Internship 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 instead of the skin test. Please obtain a 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 _____