



OakBend Medical Center  
 1705 Jackson Street  
 Richmond, Texas 77469

## Summer Internship Program Application

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

Education		
<b>SCHOOLS ATTENDED- Current School First</b>		
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 \_\_\_\_\_

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For Office Use Only:  
Rotation assigned \_\_\_\_\_  
TB Info On File \_\_\_\_\_