TEEN – For Internal Use:
Certification:_____
Community Service: _____
_____
Drug Test: _____

LUTHERAN HEALTH NETWORK
TEEN VOLUNTEER SERVICES APPLICATION

Thank you for your interest in becoming a teen volunteer **(age 14-17)** with Lutheran Health Network. Volunteers are accepted based upon their abilities, availability and the specific needs for people to provide service to patients and support those providing care for patients.

Please return your application, signed by you and your parent or guardian, along with **two** (2) letters of recommendation to your assigned volunteer services manager. A drug screen as well as **two** (2) TB tests are a mandatory requirement before volunteer placement can begin.

PERSONAL INFORMATION

First _____ **Middle**_____ **Last** _____

Date of Birth _____ **Social Security #** _____

Parent or Guardian name(s) _____

Email _____

Address _____

City _____ **State** _____ **Zip** _____

Phone _____ **Secondary Phone** _____

EMERGENCY INFORMATION

Emergency Contact _____

Relationship to you _____ **Phone** _____

QUESTIONNAIRE

Do you have any physical conditions, which may limit your activities/abilities to perform any of the various volunteer jobs? [ ] Yes [ ] No

If yes, please explain: _____

_____

Please list special interests/hobbies/skills: _____

_____

Volunteer shifts are flexible; please select the days you are available to volunteer:

[ ] Monday [ ] Tuesday [ ] Wednesday [ ] Thursday [ ] Friday [ ] Saturday [ ] Sunday

Please check the facility you are interested in volunteering at:

[ ] Bluffton Regional Medical Center (Bluffton, IN)

[ ] Dukes Medical Center (Peru, IN)

[ ] Dupont Hospital (Fort Wayne, IN)

[ ] Kosciusko Community Hospital (Warsaw, IN)

[ ] Lutheran Hospital (Fort Wayne, IN)

[ ] Lutheran Children's Hospital (Fort Wayne, IN)

[ ] Rehabilitation Hospital (Fort Wayne, IN)

[ ] St. Joseph Hospital (Fort Wayne, IN)

EDUCATION/COMMUNITY INVOLVEMENT/WORK EXPERIENCE

School _____ Grade _____

Courses currently taking, school activities, clubs, honors, etc. _____

_____

_____

Do you have plans to continue your education after high school? [ ] Yes [ ] No

If yes, what course of study do you want to pursue? _____

_____

If unknown, what career do you hope to pursue as an adult? _____

_____

List any community affiliations (church, civic groups, etc.) _____

_____

Are you seeking volunteer work as a requirement for any of the above groups? [ ] Yes [ ] No

If yes, please explain: _____

_____

Have you ever volunteered in the past before (school, civic, etc.)? [ ] Yes [ ] No

If yes, please explain: _____

_____

_____

OTHER

How did you hear about the Teen Volunteer Program? _____

_____

Do you have any friends, relatives, acquaintances employed or volunteering at the hospital?

[ ] Yes [ ] No

If yes, please list (name, position, relationship): _____

_____

_____

Briefly explain why you want to join our Teen Volunteer Program: _____

_____

_____

SPECIAL SKILLS/INTERESTS

[ ] Typing

[ ] Filing

[ ] Computer Operations

[ ] Audio Visual

[ ] Photography

[ ] Music

[ ] Art (painting or other)

[ ] Sewing/Needlework

[ ] Gardening

[ ] Crafts

[ ] Calligraphy

[ ] Games

[ ] Other: _____

PARENT/GUARDIAN SIGNATURE

I hereby permit by son/daughter/charge _____ to participate in the Teen Volunteer Program. I also give permission for a drug test to be completed on my son/daughter/charge for participation I this program and understand that I will be informed if the test is positive. I further release the hospital from any legal or other responsibilities for any injuries, act, or incidents involving the volunteer.

Parent/Guardian Signature: _____

Date:_____ Phone numbers_____

TEEN VOLUNTEER APPLICANT SIGNATURE

I hereby submit my application and letter of reference for the Teen Volunteer Program. I agree to do a drug test for participation in this program and understand that a positive test result will be provided to my parent/guardian. I understand that the Volunteer Services Manager makes all regular assignments, based on a personal interview and the interests of each prospective teen volunteer. I agree to abide by the policies and procedures of the Volunteer Services Department.

Confidentiality Agreement:

I understand and agree that, in the performance of my duties as a teen volunteer, I must hold patient/medical information in confidence. Information should not be discussed with any individuals including co-workers, other volunteers or family. I also understand that any violation of patient confidentiality will result in termination from the volunteer program.

Teen signature: _____

Date:_____ Phone number_____

Please return signed application to the volunteer services manager at the facility of your choice, which can be found on: https://lutheranhealth.net/volunteering. Signed and completed forms may be sent to the appropriate address or emailed to the facilities' volunteer manager listed. If you have any questions, please call or email your facilities' volunteer services manager.

Dupont, Kosciusko Community, Lutheran, Rehabilitation and St. Joseph hospitals are owned in part by physicians.