STAMFORD HEALTH
Healing. Reimagined.

Dear Prospective Junior Volunteer,

Thank you for your interest in Stamford Health's Junior Volunteer Program.

Please read the directions carefully as your application will not be considered unless everything is completed and returned to the Volunteer Office by our deadline. **There will be no exceptions. All applicants must be available to attend orientation as this is a mandatory requirement.**

1. The deadline for our programs is as follows:

- **High School Senior Internship Program is open to graduating seniors, class of 2019. Applications are due by February 8, 2019. The orientation will be held on the 29th of April from 9am to 1pm.**

- **Summer Program applications are due by March 8th, 2019. The orientation will be held on the 25th of June from 9am to 1pm. The program will begin on the 27th of June and will end on the 22nd of August, but students may continue until school begins. Applicants must be between the ages of 14 years to 17 years of age old to be considered. If you are currently volunteering and would like to continue you are welcome to do so.**

2. Please fill out the application. **A completed application consists of your immunization record including your PPD test for tuberculosis (within the last 12 months).**
   a) Your parent or legal guardian must sign the permission slip – next page.

3. Attach a typed 150-word essay, explaining why you would like to volunteer, and what qualities make you an exceptional candidate for Stamford Hospital's Junior Volunteer Program.

4. Ask your teacher or counselor to fill out the recommendation and scan to cprice@stamhealth.org or fax to: (203) 276-6121 or mail it in a separate envelope.

5. After review of your completed forms, you will be notified if you have been accepted for an interview by email.

6. All completed forms must be**:** scanned to cprice@stamhealth.org or fax to: (203) 276-6121. You may also mail completed forms to:

   Stamford Health
   Volunteer Services Dept.
   P.O. Box 9317
   Stamford, CT 06904-9317

7. **All volunteers are required to complete 50 hours of service for the school year. If volunteering in the summer you must complete a minimum of 25 hours and must be able to dedicate your time to our 6-week program, minimum of two (3) hours on a weekly schedule. This is required upon issuing any recommendations.**

If you have any questions about our program, please call Christina Price, Volunteer Services Department at (203) 276-7358.

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Date Office Received Application_____

Stamford Health Junior Volunteer Application

Name: _____ Date:_____

Home Phone: _____ Cell Phone: _____

Street: _____ City: _____ State: _____ Zip: _____

Age: _____ Date of Birth: _____ Student's e-mail:_____

Parent(s)/Guardian(s) Name: _____Cell: _____

Please note: If you would like us to include your parent or guardian on your email please indicate

Parent(s)/Guardian(s) Name: _____Email:_____

Parent(s)/Guardian(s) Name: _____Cell: _____

Name of School: _____ ____Grade: _____

Guidance Counselor: _____ ____contact number: _____

Student's Signature_____

Please check one or more:

☐ Office Support	☐ Arts & Entertainment	☐ Patient Support

How did you hear about us? _____

Special talent/language skill: _____

Identify the days and times you're available weekly:

Days: Time:	Mon.	Tue.	Wed.	Thurs.	Fri.

Office Use Only:

Starting Date: _____Assignment: _____

Day(s): _____Time(s):_____

Comments: _____

_____

_____

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Stamford Hospital Parent Permission

To be completed by parent or legal guardian.

Name of parent /legal guardian: _____

Home Phone: _____Work: _____

Family Doctor: _____ Phone#: _____

Does your son/daughter have any health concerns that you feel we should be aware of?

_____

_____

I grant permission for my son/daughter to be a volunteer at Stamford Hospital. I verify the age given to be correct. I will accept the judgment of the Manager of Volunteer Services concerning matters relating to my son/daughter as a volunteer.

_____ _____

Signature of parent/legal guardian Date

Consent for Treatment

All minors (under the age of 18) must have on file Consent for Treatment Form. This is a preventable measure in case of illness or injury while on duty, and would be used only after reasonable attempts to reach the parent or guardian had been made.

In the event_____ (name) required medical and/or surgical treatment while volunteering within Stamford Health System, I, the undersigned, hereby give my consent for any medical and/or surgical treatment as the attending physician and/or surgeon deems necessary. This includes the use of anesthetics. I have read the foregoing and understand it.

Signature of parent/legal guardian Date:

_____ _____

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Student Volunteer Recommendation

Dear Teacher/Counselor:

The student listed below has applied to be a volunteer within Stamford Health System. We require an honest evaluation of each applicant so that we may place him/her in an appropriate position. All of this information is strictly confidential. Thank you for your cooperation. If you have any questions, please contact us at 203-276-7358.

Mail to: Stamford Hospital
Volunteer Services Department
P.O. Box 9317
Stamford, CT 06904-9317

Or Fax to: (203) 276-6121

Student's Name: _____ Phone#: _____

School and Grade: _____

Please rate the following (Excellent/ Good/ Fair/ Poor):

Attendance: _____

Academic Standing: _____

Follows Directions: _____

Works Independently: _____

Handles Responsibility: _____

Are there any disciplinary problems that could affect the student's ability to volunteer?

_____

Additional Comments:

_____

_____

_____

_____ _____

Signature Date Title

_____ _____

Print Name Telephone #

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Health Reference

For the wellbeing of our students and patients, it is important to have up-to-date records on the health of our volunteers.

Name of Student: _____

I certify that _____ is in good health and has no health condition that would prevent him/her from participating in Stamford Hospital's Volunteer Program.

- A copy of an updated immunization record within the last 12 months has been provided to the student.
- TB Test within the last 12 months
- Flu Vaccine for the current Fall Season

Signature of physician/nurse: _____Date:_____