



Dear Prospective Volunteer:

Thank you for your interest in the Volunteer Program. Being a Volunteer is a very rewarding experience. In addition to the satisfaction you receive from helping others, you will also gain insights into the medical field as a possible profession.

To be a Volunteer you must:

1. Be 14-18 years old
2. Complete the application containing your signature and that of a parent or guardian.
3. List two personal references (individuals who are over 18 years old and not a member of your immediate family).
4. Attend the general orientation session on June 20, 2012 at the hospital and the training session for the facility at which you are assigned.
5. Complete the health history form.
6. Maintain average grades in school (C average).
7. Accept your assignment in good faith and be present when scheduled or arrange for a replacement. Volunteering is a commitment.

You will receive a letter prior to the general orientation notifying you of your assigned facility. If you have any questions, please call Cindy Clark at 715-284-1391, or email clarkc@brmh.net or contact Sarah Osegard at 715-284-3606, or email osegards@brmh.net.

We look forward to meeting you.

Sincerely,

Cindy Clark and Sarah Osegard
Volunteer Services Department

Please return the completed application, permission form,
personal release and health record by **June 3rd** to:

Black River Memorial Hospital
Attn: Sarah Osegard
711 West Adams Street
Black River Falls, WI 54615

VOLUNTEEN APPLICATION FORM

Date: _____

Please circle T-shirt size: XL L M S
(shirts are adult size)

Name: _____

Address: _____
Street City State Zip

Phone #: _____ Birth Date: _____ Age: _____

School Attending: _____

Present Grade in School: _____ Graduation Year: _____

School Activities: _____

Other Activities: _____

Career Plans: _____

Currently Employed? _____ Company: _____ Hrs per Week: _____

Father: _____ Work/Cell Phone: _____

Mother: _____ Work/Cell Phone: _____

Emergency Contact: _____ Phone #: _____

Family Physician: _____ Phone #: _____

Do you have any physical restrictions, limitations, or health problems which may affect your performance as a volunteer? Please describe: _____

How did you become interested in becoming a volunteer? _____

Number the following facilities in order of preference (First, second, third choice):
Pine View _____ Family Heritage _____ Black River Memorial Hospital _____

List two character references, not relatives (teacher, clergyman, employer):

Name	Mailing Address	Phone
_____	_____	_____
_____	_____	_____

I understand that if accepted as a Volunteer, it is my responsibility to read the rules and regulations for Volunteers, to be prompt and regular in my service and to perform my assigned duties to the best of my ability.

Signature of Applicant _____

Date _____



Volunteer Program
PARENTAL PERMISSION FORM

Date: _____

I hereby give permission for my son/daughter _____ to participate in the Volunteer Program at Black River Memorial Hospital or Pine View Care Center or Family Heritage Care Center. I certify that my son/daughter is _____ years of age and that his/her birth date is _____.

I also authorize any health screening that is required for participation in the Volunteer Program.

I understand that as a volunteer my son/daughter is making a commitment to the hospital and/or nursing homes. He/she has an obligation to carry out the responsibilities he/she undertakes. I will take part in this commitment by assuring that he/she will report on time for assignments. I will also make sure notice is given when he/she cannot be there at the scheduled time.

Signature of Parent/Guardian

Home Phone

Work Phone

Cell Phone



Consent to Photograph/Interview/Video

I hereby consent to and authorize Black River Memorial Hospital and its agents, staff and representatives to make, use, edit, reproduce and publish any of the following (strike if not applicable): photographs, video, verbal comments, written comments, taped interview and other audiovisual records of me. I consent to and authorize the use of these items in the following manner (strike if not applicable): internal publications, community or public announcements, internet/website, email, social media, release to the media, and patient and medical professional education. This consent shall act to expressly release from liability Black River Memorial Hospital, any and all of its staff, its agents, representatives, consultants and physicians.

Name (printed) _____

I am over 18 years of age: Yes No*

Signature of above-named person Witnessed by

Address _____ Address _____

Date _____ Date _____

*If the above-named person is under 18 years of age or is otherwise unable to consent, consent should be given by parent or guardian as follows:

I hereby certify that I am the parent or guardian of _____.

The person named above is unable to consent because _____.

For the above-named person, I do hereby give my consent and authorization to the foregoing on behalf of him/her/they.

Signature of guardian or parent Signature of witness

Thank you!

VOLUNTEER SERVICE HEALTH RECORD

IDENTIFICATION DATA

Fill in the following information. Please print.

Name: _____ Phone Number: _____

Address: _____
Street
City
State
Zip

Emergency contact name: _____ Phone Number: _____

To the best of my knowledge I am free from contagious disease and know of no condition which would prevent me from performing volunteer activities.

I further consent to a pre-service TB skin test and rubella testing, if indicated.

Signature: _____ Date: _____

Health History: Have you had or do you have any of the following conditions/diseases? If yes, please explain.

Disease/Condition	Yes	No	Disease/Condition	Yes	No
Cancer			High Blood Pressure		
Hepatitis/Liver Disease/Jaundice			Rheumatic Fever		
Diabetes			German Measles		
Epilepsy/Seizures			Tuberculosis/Positive TB skin test		
Kidney Problems			Chicken Pox		
Heart/Cardiac Problems			Mental Illness		
Hearing Disorder/Loss			Asthma/Respiratory/Lung Disease		
Surgical Procedures			Musculo-Skeletal Problems (sprains, strains, back problems, etc.)		

Explanation if answered yes: _____

Childhood Illnesses: (Check if you have had)

Measles _____ German Measles (Rubella) _____ Whooping Cough _____
 Scarlet Fever _____ Polio _____ Mumps _____
 Shingles _____ Other _____

Immunization Dates: MMR #1 _____ #2 _____ Tetanus _____ Hepatitis B _____

Allergies: Medications _____ Foods _____ Latex _____

Describe your reaction(s) to the items listed above _____

****Please attach a copy of your immunization card.***