Dear Prospective Volunteen:

Thank you for your interest in the Volunteen Program. Being a Volunteen 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 Volunteen 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 25, 11:30 am-3:30 pm at the hospital and the training session for the facility at which you are assigned. (Note: our orientation day may have to change if the last day of school changes!)
5. Complete the health history form.
6. Maintain at least 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 **May 17, 2019** to:

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

VOLUNTEEN APPLICATION FORM

Date: ____________________________ Please write T-shirt size: ________________
(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 volunteen? Please describe: ____

____

How did you become interested in becoming a volunteen? ______________________________

____

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 Volunteen, it is my responsibility to read the rules and regulations for Volunteens, to be prompt and regular in my service and to perform my assigned duties to the best of my ability.

____ ____________________
Signature of Applicant Date

PARTNERS OF
Black River
MEMORIAL HOSPITAL

Volunteen Program

PARENTAL PERMISSION FORM

Date: ____________________

I hereby give permission for my son/daughter ___________________________________ to participate in the Volunteen 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 Volunteen Program.

I understand that as a volunteen 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

PARTNERS OF
Black River
MEMORIAL HOSPITAL

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/them.

______________________________ ______________________________
Signature of guardian or parent Signature of witness

Thank you!

PARTNERS OF Black River MEMORIAL HOSPITAL

VOLUNTEEN 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.