LAC+USC MEDICAL CENTER
Volunteer Service Department
1200 N. State Street, IPT, 1st Floor, Room 1K311
Los Angeles, CA 90033
Telephone(323) 409 -6945

OFFICE USE ONLY

Vol. #

JUNIOR VOLUNTEER APPLICATION

1. Name -Last	First	Middle	Social Security #	Sex F ☐ M ☐	Birth date
2. Address Number Street	Apt. #	City	State	Zip Code	
3. your cell phone number	Parents cell phone #	Parents E-Mail	Volunteer E-mail address		
4. Parent/Legal Guardian Name	Parent /Legal Guardian Address	Daytime telephone			
5. Medical Insurance Name & Policy Number	Physician's Name	Phone Number			
6. Name of School Presently Attending -	Address	Grade	GPA	Graduation Year	

7. Previous Volunteer Experience and duties completed	8. Does someone you know work/train or volunteer at LAC+USC Medical Center? Yes No Name _____ relationship to you _____
9. Hobbies/sports	10. What career are you interested in ?
11. Personal talents/skills	12. When you think about volunteering, what type of things interests you?
13. School Activities presently involved with:	14. Why do you want to volunteer at this hospital?
15 What areas would you like to volunteer in? Circle ONE a. Child care b. Patient Carea Units c. Office/Clerical d. Clinics e.Guest services f.shops	What do you hope to gain from your volunteer experience? 16.

17. What days and times are you available? You may only volunteer during office hours : 7:30 a.m.- 6:00 p.m Mon - Fri & Sat 7:30 a.m- 4:00 p.m / Must be available a minimum of one 4 hour shift per week or two 2 hour shifts per week

Days	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Time						

H5641-1 (Rev.2013)

As Junior Volunteer I understand that I am required to be a student between the ages of 14 and17 1/2

- Have a written consent from a parent or guardian.
- Provide a copy of my most recent report card with a GPA of 2.5+
- Have this applicationl signed by my a school counselor and include a recommendation letter completed by _____ of person making the recommendation
  Name
- Follow the hospital rules and regulations as specified on the Volunteer Agreements
- Contact the Volunteer Coordinator immediately prior to any need to absences from my volunteer assignment.
- Volunteer a minimum of 200 hours total with a minimum of 4 hours per shift per week.

_____ _____
Signature of Applicant Date

PARENT AUTHORIZATION TO PARTICIPATE AND MEDICAL RELEASE

This authorizes _____to participate in volunteer activities at LAC+USC Healthcare Network directed by the Hospital's Department of Volunteer Services. The LAC+USC Healthcare Network is release from any liability for any illness or injury resulting to said minor while participating in such volunteer activities when it does not result from fault or neglect on the part of the Medical Center. I give permission for my child to have a semiannual TB test or annual Chest X-ray (if necessary), and blood test for rubella, measles, and chickenpox. I give permission for my child to have emergency treatment in the case of an accident or injury while on duty at LAC+USC Medical Center.

Print Name _____

Parent/guardian signature _____ Date_____

Relationship to minor (Parent or Legal Guardian) _____

Emergency Contact: _____ Phone Number:_____
(Relationship to minor)

Este documento autoriza a _____a participar en actividades del departamento de Voluntarios. El Centro Medico LAC+USC se exime de toda responsabilidad por enfermedad o lesiones causadas a dicho (a) menor mientras participa en dichas actividades voluntarias cuando estas no resulten por culpa o descuido de parte del Centro Medico. Doy mi permiso para que mi hijo/hija se someta a una prueba de tuberculosis o Rayos X del pecho (si fuese necesario), y una prueba de sangre para detectar si tiene antivirus de la rubéola, sarampión y varicela. Doy me permiso/autorización para que le den tratamiento medical de emergencia en caso de accidente o lesiones mientras este prestando servicios voluntarios en el Centro Medico LAC+USC.

Imprima el Nombre _____

Firma _____ Fecha _____

Relación/parentesco con el menor (padre o tutor) _____

Nombre de persona en caso de emergencia: _____ Telefono#:_____
(Relacion con el menor)

FOR USE BY HIGH SCHOOL CAREER COUNSELOR ONLY

Grade Point Average (must be a minum of 2.5) _____

Counselor's Signature _____ Date _____

School Name:_____ _____

Phone Number: _____ Ext.:_____

FOR OFFICE USE ONLY

	Date	BY	Comment
Application reviewed & Accepted	_____	_____	_____
Interview Scheduled	_____	_____	_____
Orientation	_____	_____	_____
Livescan FP/ EHClearance	_____	_____	_____

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As a junior volunteer applicant you are to obtain a personal letter of recommendation from a school counselor, teacher, or adult non family member who has worked with you in a supervisory or professional capacity.

Your application will not be accepted without this recommendation. Please use the space provided below to obtain your recommendation and return it with your application.

Junior volunteer applicant name: Last First

Recommendation: _____

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Date_____

Signature of Person Making Recommendation _____Title_____

Professional Relationship to Teen_____ Contact Phone number _____