

Volunteer Application

Please print clearly

Name (first)		(middle)	(last)	
Street Address/Apt. Number			City	Zip
Home Phone Number ()	Email Address (write clearly)		Age	Birth Date/Year
Grade	Cell Phone Number ()		School	H.S. Graduation Year
Parent(s)/Guardian(s) Contact- Name(s)			(Please Circle) Work or Cell Number(s)	

Do you know any teens currently volunteering at Iowa Lutheran Hospital?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, who?		
How did you find out about the Volunteer Program?		
Why do you want to become a Volunteer?		
<input type="checkbox"/> Service Hours Number of hours needed _____ Through what program? _____ <input type="checkbox"/> Other _____		
Are you able to fulfill the required minimum six month commitment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
In what clubs, organizations, sports and school activities are you involved?		
Would any of these activities interfere with a regular weekly volunteer schedule?		
As a hospital volunteer, you are required to receive an annual vaccine for Influenza (mist or shot). Exceptions may be allowed for teens with documented proof for medical or religious reasons. Please acknowledge that you understand this policy by checking the "yes" in the box below.		
<input type="checkbox"/> Yes I agree <input type="checkbox"/> No (Please call the Volunteer Office to discuss whether volunteering at the hospital is an option for you.)		

(Complete Other Side)

If currently employed, would your job ever conflict with volunteering on your designated night? Yes No

On what night are you interested in volunteering? (circle) Monday Tuesday Wednesday Thursday

Do you have any allergies or medical conditions? (If so, list.) Yes No

In case of a medical emergency while you are volunteering whom should we call?

Parent/Guardian Name(s) _____ Phone _____

Do you have a record of founded child or dependent adult abuse or have you ever been convicted of a crime in this state or any other?

Yes No

If you have ever plead "guilty", "no contest" or been convicted of any criminal offense, please provide us with a description of the offense(s), date(s), location(s) and disposition. Criminal background checks are completed on all teen volunteers. If an offense history shows up on your background check that you did not disclose, you may NOT be considered for volunteering.

Teen Signature _____ **Date** _____

PLEASE HAVE A PARENT/GUARDIAN COMPLETE THE FOLLOWING:

(Name of Teen) _____ has my permission to volunteer at Iowa Lutheran Hospital. I understand that he/she will be expected to meet expectations in terms of time, attendance, policies and procedures in order to volunteer with us. I understand and agree that Iowa Lutheran Hospital is not responsible for monitoring daily attendance and may not notify parents of teen absences. (Parents/Guardians are welcome to call the Volunteer Office to check the attendance status of their volunteer.

I give hospital staff my permission to treat the child for whom I am responsible with medical care in the event of an emergency.

Parent/Guardian (Print Name): _____

Parent/Guardian Signature: _____ **Date** _____

Please return the completed application form to:

Volunteer Coordinator
Iowa Lutheran Hospital
700 E. University Ave.
Des Moines, IA 50316