UnityPoint Health
Des Moines

Iowa Lutheran Hospital
700 E University Ave.
Des Moines, IA 50316-2392
Phone: (515) 263-5475
Fax: (515) 263-5409

Orientation Date: ___________________

Volunteen 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? ☐ Yes ☐ No

If yes, who?

How did you find out about the Volunteen Program?

Why do you want to become a Volunteen?

☐ Service Hours Number of hours needed _____________ Through what program? _______________________________

☐ Other ____

Are you able to fulfill the required **minimum** six month commitment? ☐ Yes ☐ 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.

☐ Yes I agree

☐ 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 volunteen.

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:

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