

**AULTMAN HOSPITAL
VOLUNTEER DEPARTMENT
TEENAGE VOLUNTEER APPLICATION**

Social Security # _____ Date _____

Name _____ Phone _____

Address _____ City _____ Zip Code _____

School _____ Grade _____ Grade Average _____

Name of Counselor (as reference) _____ Birth Date _____

Father's Name _____ Place of Employment _____ Phone _____

Mother's Name _____ Place of Employment _____ Phone _____

How did you learn of our Volunteer Program? _____

Have you ever done volunteer work? _____ If so, where? _____

List of organizations to which you belong: _____ Advisor: _____

Are you presently considering a health care career? _____ If so, what? _____

Do you have any medical conditions you think we should be aware of? _____

What kind of volunteer work are you interested in? _____

How much time can you give weekly? _____ Times available _____

Do you accept that there will be certain requirements in connection with your training and assignment that must be met? _____

TURN PAGE

Signature of Parent or Guardian

Signature of Applicant

FOR OFFICE USE ONLY

Orientation Date _____ Training Date _____

School Recommendation _____

Other Recommendations _____

Comments _____

After all forms are filled out and signed, mail them back to:

Volunteer Services
Aultman Hospital
2600 Sixth Street SW
Canton, Ohio 44710

Then in 3-4 days, phone **330-363-6368** for an interview
Appointment, Monday-Friday, 8 a.m. – 4:30 p.m.

**AULTMAN HOSPITAL
VOLUNTEER DEPARTMENT
2600 SIXTH ST SW
CANTON, OH 44710
Fax # 330- 580-5537**

**This must be completed before
first day that volunteer begins**

CONFIDENTIAL

To: The Director of Volunteer Services

(Volunteer)

(Address)

(City, State, Zip Code)

The above named is free from contagious disease, and there is no
contra-indication to her/his performing volunteer activities at Aultman Hospital

Remarks: _____

(Doctor's Signature)

(Print Doctor's Name)

(Date)

Revised 3/07

Aultman Hospital Volunteer Services
Teenage Volunteer
Parental Consent for TB Testing

I, _____ (*name of parent, custodian, or guardian*), residing at the following address _____, certify that I am the _____ (*parent, parent, custodian, or guardian*) of _____ (*name of minor/volunteer*), residing at the following address _____, who is now _____ years of age. I authorize and give consent to Aultman Hospital, as part of the teenage volunteer program, to test _____ (*name of minor/volunteer*) for tuberculosis (TB testing).

Date _____

(*print name of parent, custodian, or guardian*)

(*signature of parent, custodian, or guardian*)

**AULTMAN HOSPITAL
VOLUNTEER DEPARTMENT**

Re: _____

Dear Counselor:

The above named person has made application at this hospital as a teenage volunteer. We appreciate your candid evaluation of this person's qualifications from your experience with him/her as a student. This information will not be shared with the applicant.

Thank you,

VOLUNTEER DEPARTMENT

Aultman Hospital Volunteer Services
2600 Sixth Street SW
Canton, Ohio 44710

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1. Is student presently enrolled? _____ Grade _____
2. Attendance Record _____
3. Character _____
4. Appearance _____
5. Emotional Adjustment _____
6. Grade Average _____
7. Dependability _____
8. Limitations (Physical, Social, Mental) _____
9. Would you recommend this person for volunteer work? _____
10. Comment: _____

Signed _____

Date _____ Title _____

Name of School _____