Beth Abraham
Health Services
612 Allerton Avenue, Bronx.NY 10467
(718) 519-5933

Junior Volunteer Application

Name_____ Date_____

Address_____ Date of Birth_____
(street, apt #)

_____ Telephone#_____
(city and zip code)

Social Security # _____ Working Papers _____Yes _____ No
(Optional)

Name of Guardian_____

Name of Person to Notify in case of Illness_____

Relationship _____ Telephone # _____

Why do you want to volunteer at Beth Abraham Health Services?_____

_____

Name of School _____ Principal _____

Address _____

Name of Guidance Counselor _____ Tel.# _____

Is this service to fulfill a school or religious requirement? ___ Yes ____ No

Name of religious instructor _____

Number of hours required _____ Days and times available_____

Work Experience _____

Special skills or interests _____

REFERENCES please list two references (non-relative such as teacher, clergy, etc.)

Name _____ Address _____

_____

Name _____ Address _____

_____

I will notify the volunteer Department if I am unable to keep my volunteer assignment. I agree to abide by the policies and procedures of Beth Abraham Health Services. I will be punctual, courteous, dependable and keep in confidence all information I may hear or be told concerning a patient, doctor, employee or volunteer. I confirm to the best of my knowledge that the information on this application is correct.

Signature _____ Date _____

PARENT'S OR GUARDIAN'S AGREEMENT

I permit my son/daughter _____ to serve as a Junior Volunteer at Beth Abraham Health Services. I realize the responsibilities of this position and will cooperate to help him/her to comply.

Signature _____ Date _____
(parent, guardian)

FOR VOLUNTEER OFFICE ONLY

Interview Date _____ By _____

Start Date _____ Medical Form Completed _____

Placement _____ ID Badge Given _____

Date Resigned or Completed Service _____

DATE HIPPA/ INSERVICE COMPLETED _____

SIGNATURE OF VOLUNTEER _____

Comments _____

_____

_____