Text

Description automatically generated

### *Saint Francis Hospital Junior Volunteer – School Year Application*

* High school students must be 16 to apply. Positions are limited and granted on a first come, first serve basis.
* Accepted high school students must be able to commit to a **minimum** of **40 hours**. A letter of recommendation will not be granted unless the 40 hours have been completed.
* If you are 18 or older, please also complete the background authorization check form.
* **All applicants will be notified via email** (no phone calls) whether they will or will not receive an interview. **Please be sure your email address is legible on your application as that is our preferred form of communication.**
* **Onboarding must be completed within 30 days of being accepted into the program.** Failure to complete the onboarding process within 30 days will result in automatic withdrawal from the program unless an exception has been made due to extenuating circumstances.
* Occupational health clearance is required. Once accepted, candidate must call to make an appointment with our Occupational Health department to receive health clearance. Proof of immunity to MMR and Varicella, proof of a negative TB test result within the previous year, and proof of a flu shot during the official flu season are required.

This application must be filled out by the applicant, then signed in designated areas by a parent/guardian if under the age of 18. Please email or mail the completed application to:

Volunteer Services Department  
Trinity Health of New England

114 Woodland Street, Hartford, CT 06105

Or

[VolunteerServicesTHofNE@trinityhealthofne.org](mailto:volunteerservicesthofne@trinityhealthofne.org)

Text

Description automatically generated

**JUNIOR VOLUNTEER SCHOOL YEAR APPLICATION**

**Please mail or email all pages back to:**

Volunteer Services Department  
Trinity Health of New England

114 Woodland Street, Hartford, CT 06105

[VolunteerServicesTHofNE@trinityhealthofne.org](mailto:VolunteerServicesTHofNE@trinityhealthofne.org)

Date:

Name: Social Security # (18+ only):

Address:

City: State: Zip:

Home phone #: Cell #:

Email (required): Date of Birth:

Parent/ Guardian’s Name:

Emergency Contact:

*(Name) (Relationship) (Tel. #)*

Referred by Whom?

School: Current Grade:

Career Interests:

Tell us why you want to volunteer:

Will you receive school credit for volunteering? □Yes □No

If yes, total number of hours needed: Completion Date:

How did you hear of our Volunteer Program? (check one)

□ Hospital website □Community event □Religious group (church, etc.) □Other (please specify)

School Activities:

Extracurricular Activities:

Please describe prior volunteer experience:

What are your personal strengths? Weaknesses?

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Please indicate what **day(s)** and **time(s)** you would be available (VERY IMPORTANT) | | | | | | | | |
| Day | □ Sunday | □ Monday | □ Tuesday | □ Wednesday | □ Thursday | | □ Friday | □ Saturday |
| Times |  |  |  |  |  |  | |  |

Do you have any special skills you would like to use while you volunteer? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do your parents/guardians understand that you have agreed to volunteer? □Yes □No

**To be considered, you must commit to a minimum of 40 hours of volunteering over the course of three months.**

**Applicant Agreement**

I agree that the information supplied on this application is correct and I agree to the rules and regulations of the Junior Volunteer Program at Saint Francis Hospital. I agree to commit to a minimum 40 hours of volunteering over the course of three months. I understand that a letter of recommendation will not be provided unless 40 hours have been completed.

Name of Applicant

Signature of Applicant

Date

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

**Parent/Guardian Agreement**

I give my permission for my son/daughter, if chosen, to participate in the Junior Volunteer Program at Saint Francis Hospital. I will help him/her carry out this commitment.

Name of Parent/Guardian

Signature of Parent/Guardian Date

***Parental Consent Form for Minor Volunteers (17 years old)***

Name of Applicant D.O.B

As a parent/guardian of the above minor applicant, I give my consent that a tuberculosis blood test to be done by the Department of Occupational Health at Saint Francis Hospital.

I understand that this is a requirement for volunteer eligibility with Saint Francis Hospital.

***Please answer the following questions:***

Has the applicant ever had a PPD skin test before? YES NO

If yes, were you told it was “positive” or have any redness or swelling? YES NO

Has the applicant been treated with BCG against TB in the past? YES NO

Has the applicant or any of your family ever been exposed to active TB? YES NO

Has the applicant had any viral illness or received other vaccines in the past 4 weeks? YES NO

Does the applicant currently take cancer medicine or steroids? YES NO

***Mandatory Flu Vaccine Information***

Applicant must show written proof of having received a flu shot if applying to be a volunteer during the official flu season (November – May). The Department of Occupational Health cannot administer the flu shot to minors (under age 18) so applicant must receive it from their personal physician or a reputable center for flu vaccines (CVS, Walgreens, etc.).

*If you are currently pregnant or nursing, you need to obtain written permission from your physician to have a TB blood test. Bring this permission slip with you to your Occupational Health appointment.*

Name of Applicant

Applicant Signature

Name of Parent/Guardian

Parent/Guardian Signature Date

Text

Description automatically generated

***Volunteer Reference Form***

**Please complete the top portion and enter the names, titles and telephone numbers of THREE references. Please ask your reference to write a letter or complete the evaluation segment of this form. Return this completed form with your application. A reference may not be a relative, family member or friend.**

*I hereby authorize Saint Francis Hospital to contact the following schools, places of employment, and/or persons who may aid Saint Francis in determining a suitable volunteer placement for me.*

*I hereby release from any liability and hold harmless any and all individuals and/or organizations from any and all liability for providing the requested information. I hereby consent to the release of such information.*

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Applicant Signature Date***

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Name Title Signature***

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***School/Company/Agency Phone Number***

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

**Evaluation**

**Above Average Average Below Average**

|  |  |  |  |
| --- | --- | --- | --- |
| Quality of Performance |  |  |  |
| Attendance |  |  |  |
| Interpersonal Skills |  |  |  |
| Communication Skills |  |  |  |
| Initiative |  |  |  |
| Overall Activity |  |  |  |

***Comments:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Email or Mail to:***

Volunteer Services Department  
Trinity Health of New England

114 Woodland Street, Hartford, CT 06105

[***VolunteerServicesTHofNE@trinityhealthofne.org***](mailto:VolunteerServicesTHofNE@trinityhealthofne.org)

Text

Description automatically generated

***Volunteer Reference Form***

**Please complete the top portion and enter the names, titles and telephone numbers of THREE references. Please ask your reference to write a letter or complete the evaluation segment of this form. Return this completed form with your application. A reference may not be a relative, family member or friend.**

*I hereby authorize Saint Francis Hospital to contact the following schools, places of employment, and/or persons who may aid Saint Francis Hospital in determining a suitable volunteer placement for me.*

*I hereby release from any liability and hold harmless any and all individuals and/or organizations from any and all liability for providing the requested information. I hereby consent to the release of such information.*

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Applicant Signature Date***

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Name Title Signature***

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***School/Company/Agency Phone Number***

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

**Evaluation**

**Above Average Average Below Average**

|  |  |  |  |
| --- | --- | --- | --- |
| Quality of Performance |  |  |  |
| Attendance |  |  |  |
| Interpersonal Skills |  |  |  |
| Communication Skills |  |  |  |
| Initiative |  |  |  |
| Overall Activity |  |  |  |

***Comments:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Email or Mail to:***

Volunteer Services Department  
Trinity Health of New England

114 Woodland Street, Hartford, CT 06105

[***VolunteerServicesTHofNE@trinityhealthofne.org***](mailto:VolunteerServicesTHofNE@trinityhealthofne.org)

******

***Volunteer Reference Form***

**Please complete the top portion and enter the names, titles and telephone numbers of THREE references. Please ask your reference to write a letter or complete the evaluation segment of this form. Return this completed form with your application. A reference may not be a relative, family member or friend.**

*I hereby authorize Saint Francis Hospital to contact the following schools, places of employment, and/or persons who may aid Saint Francis in determining a suitable volunteer placement for me.*

*I hereby release from any liability and hold harmless any and all individuals and/or organizations from any and all liability for providing the requested information. I hereby consent to the release of such information.*

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Applicant Signature Date***

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Name Title Signature***

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***School/Company/Agency Phone Number***

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

**Evaluation**

**Above Average Average Below Average**

|  |  |  |  |
| --- | --- | --- | --- |
| Quality of Performance |  |  |  |
| Attendance |  |  |  |
| Interpersonal Skills |  |  |  |
| Communication Skills |  |  |  |
| Initiative |  |  |  |
| Overall Activity |  |  |  |

***Comments:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Email or Mail to:***

Volunteer Services Department  
Trinity Health of New England

114 Woodland Street, Hartford, CT 06105

[***VolunteerServicesTHofNE@trinityhealthofne.org***](mailto:VolunteerServicesTHofNE@trinityhealthofne.org)