Hackensack Meridian
Mountainside Medical Center

JUNIOR VOLUNTEER APPLICATION

Date: _____ **Miss** ☐ **Mr.** ☐ **Ms.** ☐
Name: _____ **Nickname, if any:** _____
Address: _____
Date of Birth: _____ **Social Security #:** _____
Phone Number: _____ **School Grade:** _____

Cell Number: _____
E-Mail: _____

Name of School you attend/address:

_____

_____

Do you have past experience as a volunteer? (If yes, please explain):

Please check the type(s) of volunteer tasks that interest you.

Clerical/non-typing	☐	Filing	☐	Filling water pitchers	☐	Collating Paperwork	☐
Transporting patients	☐	Answering phones	☐	Directing visitors	☐	Delivering items	☐

Days and hours that you are available to volunteer:

_____

Emergency Contact:
(Name) _____ **(Number)** _____

Physician's name, address, and phone number:

_____

_____

_____

Do you have a family member who presently works for Hackensack Meridian Mountainside Medical Center?

_____

If yes, please list their name, their relationship to you, and their location:

Applicant's Signature: _____ **Date:** _____

Parental Consent:

My child _____ is at least 16 years of age or older and has my consent to serve as a junior volunteer at Hackensack Meridian Mountainside Medical Center. He/she is in good health and upon completion of the required training course, will be responsible for completing their volunteer assignment. The Director of Volunteer Services will determine the volunteer assignment during an interview.

Parent Signature _____ **Date** _____

Relationship _____ **Cell Phone #** _____