Date ____________________ Email ____________________ Birthdate ________

JUNIOR VOLUNTEER REGISTRATION FORM

MEDICAL CITY FORT WORTH

NAME ____
Last *First* *Middle*

ADDRESS ____
Street *City* *Zip* *Home Phone* *Cell Phone*

PARENT/S NAMES ____

ARE YOU EMPLOYED/WHERE? ____

SPECIAL SKILLS? ____

HOBBIES/CLUBS? ____

FOREIGN LANGUAGES? ____

CONVICTED OF ANY CRIMES? IF YES, PLEASE EXPLAIN: ____________________

____

PREVIOUS VOLUNTEER EXPERIENCE? IF YES, PLEASE EXPLAIN: ____________________

____

WHY DO YOU WISH TO VOLUNTEER FOR MEDICAL CITY FT WORTH? ____________________

____

DAYS PREFERRED: MON TUES WED THURS FRI HOURS: __________

PARENT EMAIL ADDRESS: ____

TWO PERSONAL REFERENCES (NO RELATIVES)

NAME ______________________________ PHONE __________

ADDRESS ____

NAME ______________________________ PHONE __________

ADDRESS ____

NAME OF PERSONAL PHYSICIAN ______________________ PHONE ______________________

ANY ILLNESS IN THE PAST YEAR? IF YES, PLEASE EXPLAIN: ______________________

____

ANY MEDICATIONS CURRENTLY BEING TAKEN? IF YES, PLEASE LIST AND WHY: __________

____

ARE YOU ALLERGIC TO ANY DRUGS? IF YES, PLEASE LIST DRUGS: ______________________

____

DO YOU HAVE ANY LIMITATIONS? IF YES, PLEASE EXPLAIN: ______________________

____

IN CASE OF EMERGENCY CONTACT ____
(*RELATIONSHIP)*

HOME PHONE ______________________ WORK PHONE ______________________

PARENTAL PERMISSION

1. THIS IS TO CERTIFY THAT OUR CHILD IS IN GOOD HEALTH AD HAS OUR PERMISSION TO PARTICIPATE IN THE JUNIOR VOLUNTEER PROGRAM AT MEDICAL CITY FORT WORTH, FORT WORTH TX.
2. VOLUNTEERS MUST HAVE A TB TEST, WHICH WILL BE AVAILABLE AT NO CHARGE, OR YOU MAY BRING A RECENT (WITHIN 90 DAYS) TEST FROM YOUR DOCTOR. VOLUNTEERS WILL BE SCREENED FOR TB ANNUALLY.
3. I UNDERSTAND THAT THE INFORMATION I HAVE PROVIDED MAY BE VERIFIED IF NECESSARY. I HEREBY RELEASE AND AGREE TO HOLD HARMLESS ANY PERSON OR ORGANIZIATION THAT PROVIDES INFORMATION. I ALSO AGREE TO HOLD HARMLESS MEDICAL CITY FORT WORTH AND ITS TRUSTEES, OFFICERS, EMPLOYEES AND VOLUNTEERS FROM LIABILITY FOR SEEKING OR RELYING UPON SUCH INFORMATION.
4. I UNDERSTAND THAT IF MY CHILD IS INJURED WHILE ON DUTY AS A VOLUNTEER AT MEDICAL CITY FORT WORTH THAT I WILL BE RESPONSIBLE FOR ALL PAYMENTS IF ANY MEDICAL SERVICES ARE RENDERED. I ALSO GIVE MY PERMISIION FOR MY CHILD TO PERFORM THE DUTIES REQUIRED.

PARENT ______________________________________ DATE ______________________

I UNDERSTAND THAT IN ORDER TO BE A JUNIOR VOLUNTEER I MUST ABIDE BY ALL RULES AND REGULATIONS. I ALSO UNDERSTAND THAT I MUST BE IN FULL UNIFORM EACH AND EVERY DAY I AM VOLUNTEERING OR I WILL BE ASKED RETURN HOME AND VOLUNTEER ANOTHER DAY.

VOLUNTEER ______________________________________ DATE ______________________

OPPORTUNITIES FOR VOLUNTEERS ARE PROVIDED WITHOUT REGARD TO RELIGION, CREED, RACE, NATIONAL ORIGIN, AGE, SEX or DISABILITY STATUS TO OTHERWISE QUALIFIED INDIVIDUALS.

Contact:

Barbie Thompson, Volunteer Coordinator | Ph: 817.347.1436 | Barbara.Thompson@MedicalCityHealth.com