



Please mail to:
 St. Mary's Medical Center
 407 East Third Street
 Duluth MN 55805
 (218) 786-4420

Junior Volunteer Application

*Volunteer Services Mission Statement:
 Volunteer Services is dedicated to provide the highest
 quality of volunteer support to those we serve within the
 regional Health System.*

Please advise us if any accommodation is needed to participate in the application process.

Date _____

Are you required to volunteer? No Yes - by whom? _____

First/Middle/Last Name		Are you 13 ½ or older Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you 18 or older Yes <input type="checkbox"/> No <input type="checkbox"/>
Complete Mailing Address		City	State Zip
Email	Home Phone	Cell Phone	

EMERGENCY CONTACT		
Name	Relationship	Day Time Phone

EDUCATION AND WORK EXPERIENCE	
Current Employer	Circle Current Grade 8 9 10 11 12
Work Phone	School Attending 2009 - 2010
Position Responsibilities	Graduation Date
Have you ever been employed with SMDC Health System? Yes <input type="checkbox"/> No <input type="checkbox"/> From _____ To _____ (Month/Yr)	
Facility/Department:	Your Name at the time:

Skills	Volunteer Work Preference	Availability								
<input type="checkbox"/> Helping Visitors	<input type="checkbox"/> Adult Setting	Can you commit to volunteering at a regular scheduled time? Yes <input type="checkbox"/> No <input type="checkbox"/> Please check below days and times you can volunteer								
<input type="checkbox"/> Helping Patients	<input type="checkbox"/> Children Setting									
<input type="checkbox"/> Helping Customers	<input type="checkbox"/> Visitor Setting									
<input type="checkbox"/> Helping Staff	<input type="checkbox"/> Patient Setting									
<input type="checkbox"/> Errands/Delivery	<input type="checkbox"/> Customer Setting	<table style="width: 100%; border-collapse: collapse;"> <tr> <td></td> <td>S</td> <td>M</td> <td>T</td> <td>W</td> <td>TH</td> <td>F</td> <td>S</td> </tr> </table>		S	M	T	W	TH	F	S
	S	M	T	W	TH	F	S			
<input type="checkbox"/> Answering Phones	<input type="checkbox"/> Hospice Setting	Early Morning								
<input type="checkbox"/> Mailings/Filing/Labeling	<input type="checkbox"/> Hospice House Setting	Mid Morning								
<input type="checkbox"/> Word Processing/Data Entry	<input type="checkbox"/> Office Setting	Early Afternoon								
<input type="checkbox"/> Education Packets	<input type="checkbox"/> Delivery Setting	Mid Afternoon								

Please check which volunteer location you prefer	<input type="checkbox"/> St. Mary's Duluth	<input type="checkbox"/> St. Mary's Superior	<input type="checkbox"/> SMDC Medical Center (Miller Dwan Bldg.)	<input type="checkbox"/> Solvay Hospice House	<input type="checkbox"/> Other
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How did you hear about Volunteering? _____

Why do you want to volunteer? _____

- The information in this application is accurate and correct to the best of my knowledge.
- I agree as a volunteer my time and talents will be given freely without any expectation of monetary reimbursement.
- I am participating in a community program, which reimburses me for volunteer service hours.

Your Signature _____ Date _____

PARENTAL/GUARDIAN CONSENT

_____ Has my consent to serve as a Junior Volunteer and is 13 ½ years of age or older.

I am aware that I am responsible for transportation of my child to and from the hospital during assigned volunteer hours.

I understand the responsibility of a junior volunteer and **I will encourage her/his promptness and regularity** of service.

I authorize St. Mary's Medical Center to provide **emergency medical assistance** to my child if she/he becomes ill or injured while here doing volunteer services. I authorize St. Mary's Volunteer Services to perform **criminal record background checks** as required by law.

I do hereby grant my permission for SMDC Volunteer Services to display and/or publish photographs, interviews, and/or videotapes of my child.

I decline my permission for SMDC Volunteer Services to display and/or publish photographs, interviews, and/or videotapes of my child.

Signature of parent/guardian _____ **Date:** _____

Volunteer opportunities are provided without regard to religion, creed, race, national origin, sexual orientation, age, gender, disability, marital status or status with regard to public assistance. SMDC does not imply that you will be assigned a volunteer position and this application should not be construed as a contract or promise of a volunteer position.



Reference for Youth Volunteer Applicant

Date _____

Applicant's Name _____

Address _____

School _____

Teacher/Counselor _____

This student has applied to be a volunteer with SMDC Health System. It will help us to evaluate the student's abilities and suitability for volunteer work in a medical setting if you will answer the following questions:

According to your records and knowledge, please rate this student on the following traits:

Responsibility _____

Cooperation _____

Emotional Maturity _____

Judgment/Common Sense _____

Moral Character _____

Intelligence _____

Attendance at School _____

Please make any additional comments you believe would be beneficial:

Signature of teacher/counselor _____

Parents/Guardian: State and Federal legislation requires that schools must have parental consent to release information regarding students. Please sign this form and have your child submit it to a teacher or school counselor to be completed and returned.

Signature of parent/guardian _____

Attention Teacher/Counselor: Please return reference to student's volunteer site:

Joy Miller, Volunteer Supervisor
St. Mary's Medical Center
407 East Third Street
Duluth MN 55805