



Shriners Hospitals
for Children®

2019 VOLUNTEEN SUMMER PROGRAM APPLICATION

Name: _____
(First name) (Middle initial) (Last name)

Mailing Address: _____ City/State: _____

Zip: _____ Home Phone #: _____ Cell Phone #: _____

E-mail: _____ Birth Date (mm/dd/yy): _____
(Please print clearly)

Male Female School: _____ Grade: _____

Emergency Contact: Guardian's name & daytime telephone number

Guardian 1: _____ Relationship _____ Phone # _____

Guardian 2: _____ Relationship _____ Phone # _____

Physician's Name: _____ Phone #: _____

Volunteer hours required by school or organization Yes No Hours required: _____

Please list any special skills: _____

Are you currently interested in pursuing a career in a health related profession? Yes No

In what field? _____

Assignment Preference: Please circle days that you will be available. Minimum commitment hours for the 6 week summer program period — 12 hours per week (or more).

Preferred days: MON TUES WED THURS FRI

Preferred shift: Morning shift between the hours of 9am-1pm Afternoon shift between the hours of 1-5pm

Are there any areas/departments within the hospital that you **would not** be comfortable working in?

Yes No If yes, where? _____

Please note that not all departments in the hospital are appropriate for student volunteers and some departments do not have opportunities for this age group. We will try to place you in an area of interest but assignments will depend on number of students, number of available positions and the day/shift that you are available.

REFERENCES: (required)

A letter from your school's guidance counselor, teacher, clergy, or someone other than a relative.

ESSAY: (required)

Please attach a short essay (at least 2 paragraphs) explaining why you want to volunteer at SHC-HOU and what you feel you can gain and/or contribute to SHC-HOU.

Have you ever been convicted of or pled guilty to a criminal offense other than minor traffic violations?

___ Yes ___ No

If yes, please explain: _____

APPLICANT'S RESPONSIBILITY:

Should I be accepted as a VolunTEEN at Shriners Hospital—Houston, I am aware that I will be expected to abide by the guidelines and policies of the hospital's Volunteer Program and to be on duty when assigned except when absent because of illness. If I am unable to report for assigned duty, I fully understand it is **my responsibility** to notify in advance the Volunteer Coordinator, Jason Hinestroza at jhinestroza@shrinenet.org or 713-793-3702 and the supervisor of the area to which I am assigned.

Applicant's Signature: _____ Date: _____

PARENT/GUARDIAN PERMISSION:

I hereby certify that my son/daughter will be 15 years of age or older by June 1, 2019 and give my permission for _____ to serve as a VolunTEEN at Shriners Hospital for Children-Houston. I understand my son/daughter will be expected to abide by the policies of the VolunTEEN Summer Program. Transportation to and from the hospital is our responsibility. I also understand that the hospital is not responsible in case of an accident.

Signature: _____ Date: _____