BAY
REGIONAL MEDICAL CENTER
A McLAREN HEALTH SERVICE

# JUNIOR VOLUNTEER APPLICATION

| | DATE |
|---|---|

| LAST NAME | FIRST | MIDDLE |
|---|---|---|

| ADDRESS | STREET | CITY | STATE | ZIP |
|---|---|---|---|---|

| HOME PHONE NUMBER | CELL PHONE NOMBER | DATE OF BIRTH | AGE |
|---|---|---|---|

| MICHIGAN DRIVERS LICENSE NUMBER | E-MAIL | GENDER ☐ MALE ☐ FEMALE |
|---|---|---|

**ARE YOU PRESENTLY A STUDENT?** ☐ YES ☐ NO **IF YES, WHERE:**

| GRADE | SCHOOL COUNSELOR |
|---|---|

**ARE YOU CURRENTLY EMPLOYED?** ☐ YES ☐ NO **IF YES, WHERE:**

**PREVIOUS WORK EXPERIENCE**

**HAVE YOU EVER BEEN A VOLUNTEER?** ☐ YES ☐ NO IF YES, WHERE?

**WHAT ARE YOUR INTERESTS?**

**ARE YOU AWARE OF ANY MEDICAL, PHYSICAL OR MENTAL HANDICAP THAT WOULD AFFECT YOUR ABILITY TO PERFORM VOLUNTEER DUTIES?** ☐ YES ☐ NO

**EXPLAIN:** ____________________

## REFERENCES (Other than relatives)

| NAME | PHONE NUMBER |
|---|---|

| ADDRESS | STREET | CITY | STATE | ZIP |
|---|---|---|---|---|

| NAME | PHONE NUMBER |
|---|---|

| ADDRESS | STREET | CITY | STATE | ZIP |
|---|---|---|---|---|

## PREFERRED SERVICE AND TIME

**SERVICE AREA PREFERRED:** ____________________

| DAYS PREFERRED: | | HOURS PREFERRED: | |
|---|---|---|---|
| MONDAY THROUGH FRIDAY | ________ | MORNINGS | ________ |
| WEEKENDS | ________ | AFTERNOONS | ________ |
| HOLIDAYS | ________ | EVENINGS | ________ |

## EMERGENCY CONTACT

**NAME OF PARENT OR GUARDIAN:**

**IN CASE OF EMERGENCY PLEASE NOTIFY:**

**NAME** **RELATIONSHIP** **PHONE NUMBER**

**ADDRESS** **STREET** **CITY** **STATE** **ZIP**

## BACKGROUND CHECK (To protect your privacy, this form will only be seen by BRMC Volunteer Services staff)

**PLEASE INDICATE ANY OTHER NAME(S) EVER USED:**

**HAVE YOU EVER BEEN CONVICTED OF A FELONY OR A MISDEMEANOR?** ☐ YES ☐ NO

**IF YES, PLEASE EXPLAIN:**

I GIVE BAY REGIONAL MEDICAL CENTER PERMISSION TO CHECK MY CRIMINAL HISTORY WITH MICHIGAN LAW ENFORCEMENT AGENCIES, AND TO SEARCH MY HISTORY FOR INCIDENTS OF FRAUD WITH THE FRAUD AND ABUSE CONTROL INFORMATION DATABASE.

I UNDERSTAND THAT MY ENROLLMENT AS A VOLUNTEER IS CONTINGENT UPON SUCCESSFUL COMPLETION OF THE APPLICATION PROCESS. I GIVE MY PERMISSION FOR THE ABOVE-NAMED REFERENCES TO RELEASE INFORMATION ABOUT ME, FOR MY CRIMINAL HISTORY TO BE VERIFIED, AND TO HAVE MY HISTORY SEARCHED FOR FRAUD AND ABUSE.

IF I AM SELECTED AS A BAY REGIONAL MEDICAL CENTER VOLUNTEER I AGREE TO ABIDE BY ALL HOSPITAL RULES, REGULATIONS AND EXPECTATIONS. I UNDERSTAND THAT EITHER PARTY MAY CANCEL THIS RELATIONSHIP AT ANY TIME.

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT. I AGREE TO INFORM BAY REGIONAL MEDICAL CENTER OF ANY CHANGES.

**SIGNATURE** **DATE**

Note: A criminal history will not necessarily disqualify an applicant. A criminal record is one piece of information that will be considered in determining the appropriateness of an individual to be a Bay Regional Medical Center Volunteer.

**ACCEPTANCE AS A VOLUNTEER IS BASED ON YOUR PASSING A HEALTH HISTORY QUESTIONNAIRE. AS A VOLUNTEER, YOU WILL HAVE THE OPPORTUNITY TO LEARN A GREAT DEAL ABOUT THE HEALTH CARE INDUSTRY. THE EXPERIENCE THAT YOU ACQUIRE MAY BE OF VALUE IN THE FUTURE. HOWEVER, THE FACT THAT YOU HAVE BEEN ACCEPTED AS A VOLUNTEER BY BAY REGIONAL MEDICAL CENTER IS NOT TO BE CONSTRUED IN ANY MANNER AS A GUARANTEE OF FUTURE EMPLOYMENT OR A COMMITMENT THAT YOU MAY BE CONSIDERED FOR OR OFFERED EMPLOYMENT BY THE MEDICAL CENTER AT SOME FUTURE DATE.**

## PARENTAL CONSENT

I hereby give my consent for the above-named applicant to serve as a volunteer at Bay Regional Medical Center. I also authorize Bay Regional Medical Center and their physicians to render medical, hospital or personnel health services treatment and/or examination to the above named individual.

**SIGNATURE OF PARENT OR GUARDIAN** **DATE**

Please return this application to:
Bay Regional Medical Center, Volunteer Services,
1900 Columbus Avenue, Bay City, MI 48708