

**UNIVERSITY HOSPITALS PARMA MEDICAL CENTER
JUNIOR VOLUNTEER APPLICATION**



Please Print

Name: _____
(First Name) (Middle Initial) (Last Name)

Home Phone Number: _____ Cell Phone Number: _____

Address: _____
(Street Address) (City) (Zip Code)

E-Mail Address: _____ Age: _____ Date of Birth: _____

High School: _____ Year of Graduation: _____

Presently Employed? Yes _____ No _____ If yes, where: _____

Previous Volunteer Work? Yes _____ No _____ If yes, where: _____

List any Extra-Curricular Activities: _____

Days/Times Available to Volunteer: _____

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CONFIDENTIALITY:

As a volunteer, you will be trusted to keep confidential any information you may learn about the patients you encounter. It is especially important that you respect the individuals' right to privacy and at no time reveal his or her identity, diagnosis, or care plan. Violation of patient confidentiality will result in termination of your volunteer services at University Hospitals Parma Medical Center.

Signature of Applicant: _____ Date: _____

Parent Signature: _____ Date: _____

Emergency Contact: _____ Phone: _____

Please return the signed application, essay and 2 letters of recommendation by email to GERALYN.NOVICKY@UHhospitals.org or by mail to : Volunteer Services Department
UH Parma Medical Center
7007 Powers Boulevard
Parma, OH 44129