Shenandoah Memorial Hospital

VolunTeen Application

Name: ____Date of Birth: ___________________

Address: ____

Telephone Number: _________________________Email address: ______________________________

Parent(s)/Guardian Name(s): ____

Telephone Number: ___________________________Cell:______________________________________

School Name:____ Current Grade_____________

Volunteer and Work Experience: ____

____

Days/ Time/ Frequency Available to Volunteer:

Days	Times	
_________Monday	8-12	12-4
_________Tuesday	8-12	12-4
_________Wednesday	8-12	12-4
_________Thursday	8-12	12-4
_________Friday	8-12	12-4

Vacation/time off Dates (please list any dates that you will be unable to volunteer. VolunTeens can only miss two weeks per summer)

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____

Do you have any allergies? (Medications, Foods, Environmental) __________________________________

____

What has motivated you to offer your services on a Volunteer basis at Shenandoah Memorial? _________

____

____

By signing below, I do hereby affirm that all of the information listed above is true to best of my knowledge and I give Valley Health the right to check on my background and release from all liability or responsibility all person, companies, or corporations supplying this information.

Signature: ____Date: ____________________________

MBS 2/2019