



**RMC**

Regional Medical Center

Volunteers Program

# APPLICATION 2019



**June 17—July 26, 2019**

Program Dates

**Application due by May 2th**

(4:30 PM)

(Incomplete or late applications will not be considered)

**PO Box 2208, Anniston, AL 36202**

Please keep the cover page for a listing of dates

Return six pages in proper order



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**All correspondence from RMC will be via email. Please provide the email address that you read regularly. Please PRINT legibly.**

\_\_\_\_\_ @ \_\_\_\_\_.

PLEASE PRINT

Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ AL \_\_\_\_\_ zip \_\_\_\_\_

Phone Home ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Emergency Phone ( ) \_\_\_\_\_ ( ) \_\_\_\_\_

School Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ AL \_\_\_\_\_ zip \_\_\_\_\_

Phone ( ) \_\_\_\_\_

Grade entering in Fall 2018 \_\_\_\_\_

**THIS IS MY 1st \_\_\_\_ 2nd \_\_\_\_ 3rd \_\_\_\_ 4th \_\_\_\_ year as a Volunteer**

**Selection and Assignment will be determined during Orientation**

**List all school classes / activities that show your interest and work toward a health care career. Your specific interest (if known).**

*When assigning your placement, consideration for your interest will be given. However, RMC reserves the right to place the Volunteer in the area where he/she may be most suited to the hospital, staff and patients. Priority will be given in order of seniority in the program.*



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**I am available to volunteer on the indicated day (s) and time (s)**

**Shift selection will be made from your available days/time. Due to the number of participants in the program, only one shift assignment per participant.**

**(Circle below).**

Monday	8:30 AM – 12 PM	1 PM – 4 PM
Tuesday	8:30 AM – 12 PM	1 PM – 4 PM
Wednesday	8:30 AM – 12 PM	1 PM – 4 PM
Thursday	8:30 AM – 12 PM	1 PM – 4 PM
Friday	8:30 AM – 12 PM	1 PM – 4 PM

**NOTE:**

*If you are dependent upon transportation from another person, please confer with them prior to selecting your day/time to volunteer. Once the schedule is set it may not be able to be adjusted.*

**Briefly list why you are interested in participating in the RMC Volunteers Program.**

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**Size of uniform vest (adult sizes only) (circle one) SMALL    MED    LARGE    XL    2XL**

**I have read and understand the RMC Volunteer brochure and am willing to participate in the program as outlined.**

\_\_\_\_\_  
*Applicants Signature*

\_\_\_\_\_  
*Date*



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## Parental Permission Form

I have been provided with information about the RMC Volunteers Program. I have read the information and understand it's contents. I am aware that should my child not submit the required application in a timely manner they will not be afforded the opportunity to be considered for the program. I am further aware that the orientation class is mandatory and is scheduled for Monday, June 12th at 2:00 PM—5 PM in the RMC auditorium, located on the 1st floor of the main hospital.

I give my permission for my child to participate in the RMC Volunteers Program, to be photographed while in the program, and such image may be used for RMC marketing purposes. Furthermore, I grant consent for my child to receive the required TB skin test which will be administered during a time to be announced.

I understand that if the rules outlined in the in Volunteer brochure and during orientation are not followed, my child may be asked to separate from the program.

Applicant's Name \_\_\_\_\_

\_\_\_\_\_  
*Parent / Legal Guardian's Name (please print)*

\_\_\_\_\_  
*Parent / Legal Guardian's Signature*

\_\_\_\_\_  
*Date*

## School Reference

School \_\_\_\_\_

Principal / Head Master / Home School Association President

Teacher/Counselor ( Who knows the student well)

Address \_\_\_\_\_

\_\_\_\_\_, \_\_\_\_\_ zip \_\_\_\_\_

Phone \_\_\_\_\_

Email \_\_\_\_\_

Volunteer Candidate \_\_\_\_\_

GPA \_\_\_\_\_

Attendance Record Circle One

Excellent      Good      Fair

Comments/Recommendation:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### MUST ACQUIRE BOTH SIGNATURES

\_\_\_\_\_  
*Signature* *Date*

*Principal / Head Master / Home School Association President*

\_\_\_\_\_  
*Signature* *Date*

*Teacher / Guidance Counselor*



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**Personal References for \_\_\_\_\_**

**Name** \_\_\_\_\_

**Relationship to Volunteer** \_\_\_\_\_

**Address** \_\_\_\_\_

**Day Time Phone** \_\_\_\_\_

**Name** \_\_\_\_\_

**Relationship to Volunteer** \_\_\_\_\_

**Address** \_\_\_\_\_

**Day Time Phone** \_\_\_\_\_

*References must have known the Volunteer candidate for at least two years, they must give permission to be listed as a personal reference and they must NOT be a relative.*

## Physician's Statement

**Volunteer Applicant** \_\_\_\_\_

Date of Birth \_\_\_\_\_

Print

Physician / School Nurse \_\_\_\_\_

Office Address \_\_\_\_\_

\_\_\_\_\_, \_\_\_\_\_, zip \_\_\_\_\_

Office Phone (\_\_\_\_\_) \_\_\_\_\_

***To the best of my knowledge, this person is a healthy individual and is free of communicable diseases. I feel that he/she is safe to volunteer in a hospital setting and possesses the abilities to understand and comprehend in order to follow directions.***

***Additional Comments:***

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\_\_\_\_\_  
Physician / School Nurse Signature

\_\_\_\_\_  
Date