208 Pierson Avenue
Centreville, AL 35042
(205)-926-4881
bibbmedicalcenter.com

BIBB MEDICAL CENTER

APPLICATION DATE: _____

STUDENT VOLUNTEER APPLICATION

(***MUST BE 16+ TO APPLY***)

PLEASE PRINT

Last Name	First Name	Middle Name

Gender: ◯ Female ◯ Male Preferred Nickname: _____

Home Address

Street Address: _____ How long have you lived at this address? _____	Apartment Number:

City:	State:	Zip Code:

Names of Parents or Legal Guardians: _____

Parent contact phone #: Mother: _____Father:_____

Emergency Contact: Name: _____Relationship: _____Phone #:_____

Primary Care Physician: Name: _____ Phone #:_____

Do you have any medical conditions that would affect your ability to perform your volunteer duties, or that the volunteer office should be aware of? ◯ No ◯ Yes If yes, please explain: _____

Home phone number	Cell phone number	E-Mail Address

I prefer to receive calls at ◯ Home ◯ Cell ◯ Either

Personal Information

Date of Birth	School

Grade	Career Plans

Employment Information (Check all that apply)

I am:
- ☐ Employed: __Part Time __Full Time
- ☐ Un-Employed
- ☐ Student

Current Employer's Name

Current Occupation

Work Schedule
What days do you work? What hours do you work?

Previous Employer or work experience:

Past or present volunteer experience:

Are you volunteering to fulfill a requirement of another program? _____ Required Hours: _____

Times Available: Please check times available:

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Morning	☐	☐	☐	☐	☐	☐	☐
Afternoon	☐	☐	☐	☐	☐	☐	☐
Evening	☐	☐	☐	☐	☐	☐	☐

Please circle your interests or fill in some that might not be listed:

Bingo	Library/Movie	Coloring		
Visiting (One-on-One)	Parties/Special Events	Office Work		
Fishing	Board Games			
Art	Playing Cards			
Reading	Maintenance			

To the Parent: Your signature below indicates your approval for your child's participation in the Student Volunteer Program at Bibb Medical Center and for him/her to take the required TB (tuberculosis) test, provided by the hospital at no charge. If you decline the TB test, we require a physician's statement showing your child is free from tuberculosis. Please initial here only if you decline the TB test: _____

Parent's Signature _____ Date _____

Statement of Understanding:
I hereby affirm that the information provided on this application (and any accompanying forms) is true and complete. I understand that any false or misleading representations or omissions may disqualify me from further consideration for the volunteer program and may result in discharge even if discovered at a later date.

I certify that the statements made in this volunteer application are true and complete, and have been given voluntarily. I understand that any misrepresentation or omission of fact shall be considered sufficient cause for termination of my volunteer service. I agree that Bibb Medical Center and any of the references provided on this application, may exchange information regarding my qualifications without incurring any liability whatsoever for supplying such information. I understand that I will not be paid for my services as a volunteer. I agree to abide by all organization and volunteer policies. I understand that BMC is not obligated to provide volunteer placement, nor am I obligated to accept the volunteer assignment offered.

Please note: Volunteer placement is subject to -

1. Satisfactory reference reports.
2. Satisfactory medical history review and required testing.
3. Willingness to abide by all hospital requirements and regulations.

_____ _____

Signature of Applicant **Date**

Qualified applicants shall receive consideration regardless of race, religion, color, national origin, sex, age, disability or marital status.

Your application and reference form must be returned to the hospital before an orientation will be scheduled. Thank you for your interest in our organization.

Photo/Video/Audio Release Form

I grant permission to Bibb Medical Center to use photographs and/or video/audio taken of me for use on University web sites or other electronic form, print or media, and to offer the photographs and/or video/audio for use or distribution to other University departments, without notifying me.

I hereby waive any right to inspect or approve the photographs/video/audio and/or electronic matter that may be used in conjunction with them now or in the future, whether that use is known to me or unknown, and I waive any right to royalties or other compensation arising from or related to the use of the photographs and/or video/audio.

I hereby agree to release and hold harmless Bibb Medical Center, via electronic or media, from and against any claims, damages or liability arising from or related to the use of the photographs and/or video/audio, including but not limited to any re-use, distortion, blurring, alteration, optical illusion or use in composite form, either intentionally or otherwise, that may occur or be produced in production of the finished product.

I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those question in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

Name (print): _____

Signature of Applicant: _____ Date: _____

(If under 18) Parent/Guardian Signature: _____ Date: _____

When completed, please return to:

Karen Daniel
208 Pierson Avenue
Centreville, AL 35042
(205) 926-3363
bmchr@bibbmedicalcenter.com

Volunteer Services Reference Form

An employer/previous Volunteer Supervisor, a teacher, coach, clergy, physician, landlord or someone who knows you well should provide a reference. Family members or friends may not provide a reference.

The following, _____ has applied to volunteer at Bibb Medical Center.
(Prospective volunteer)

As a volunteer, this individual would have contact with residents/clients who are vulnerable, recovering from illness and have special needs. Volunteers assist staff, residents/clients and their families in a variety of ways. Activities might include visiting, offering support and comfort, working in positions of trust and confidentiality. Volunteers are also required to work co-operatively with staff and other volunteers.

Please put completed form in a sealed envelope and return to:

Karen Daniel
208 Pierson Avenue
Centreville, AL 35042
(205) 926-3363
kdaniel@bibbmedicalcenter.com

Referee Information:

Name of Referee: _____

Organization: _____ Title Position: _____

Address: _____

Phone #: _____ E-mail: _____

Date: _____ Signature of Referee: _____

Qualities/Strengths:

1. How long have you known the applicant: _____
2. In what capacity have you known the applicant : _____
3. In your opinion, is the applicant: *(please select)*

☐ **Reliable** ☐ **Respected** ☐ **Caring**
☐ **Responsible** ☐ **Friendly** ☐ **Organized**

Other Comments: _____

4. Which of the following strengths or qualities does this individual possess that would be of value in performing volunteer duties: *(please select)*

☐ **Ability to follow instructions** ☐ **Takes initiative** ☐ **Shows sound judgment**

Other Comments: _____

5. What area(s) do you feel the applicant needs to develop or strengthen? *(please select)*

☐ **judgment** ☐ **initiative** ☐ **commitment**
☐ **interpersonal skills** ☐ **confidentiality** ☐ **co-operation**

Other Comments: _____

6. Do you recommend the applicant for a volunteer position?: ◯ Yes ◯ No

Please explain: _____

Other comments: _____