

STUDENT PROGRAM INFORMATION

We are pleased that you have expressed an interest in volunteering at St. Joseph Medical Center. Our Summer Program begins in June and runs through August, the application deadline is the last full week in March. The Fall/Winter Program is from October through April, the application deadline is the last full week in August.

Whether you are volunteering to gain service hours for school or as a means of exploring the many career choices available in health care today we want to welcome you and thank you for the valuable service you have chosen to provide our health center.

We have several requirements for participation in the Student Volunteer Program.

- The minimum age is 14. You must meet the age requirement by the time the program you want to participate in starts.
- For the Summer session you must commit to a minimum of six weeks (not necessarily consecutive) with a total of 40 hours of service. The Fall/Winter Program is also a total of 40 hours but is spaced out over 7 months with a 6 hour a month service minimum.
- The application, which follows, must be filled out on both sides and returned to the Volunteer Office.

You will be contacted about setting an appointment time for a student interview. We look forward to meeting you.

Sincerely,

Volunteer Services Department

**St. Joseph Medical Center
Volunteer Services Department**

1000 Carondelet Drive, Kansas City, Missouri 64114
816-943-2775

Website: www.carondelethealth.org

Student Volunteer Application

Welcome to St. Joseph Medical Center

We are pleased that you are interested in providing volunteer service at St. Joseph Medical Center. If you are looking for a way to become involved in a gratifying service by contributing your time, energy and skills, we invite you to share in the fellowship, friendship and celebration of achievements that come from giving.

We offer you a number of opportunities to make a meaningful difference in the lives of others. Please share your interests with us by completing the enclosed application and returning it to the address above. Once we have received your information, we will call you to schedule a time to meet.

Carondelet Health may obtain one or more consumer or background reports, such as a criminal background report or a motor vehicle driving record report on applicants and volunteers. These reports may be obtained in connection with your application or at any time during your volunteering at St. Joseph Medical Center.

Our Mission Statement:

Carondelet Health consists of Catholic Organizations dedicated to the healing ministry of Jesus Christ. Our commitment to human dignity compels us to provide compassionate, quality healthcare for body, mind and spirit with a concern for the poor. We are responsible stewards serving the needs of all people from conception to death. We are united in this mission.

Our Vision: "Service with Excellence"

Our Values: "Integrity, Compassion, Unity"

Guided by the Carondelet Health Mission, the Volunteer Services Department strives to provide quality support services through a core of highly motivated volunteers, offered with a positive and caring spirit.

St. Joseph Medical Center Student Volunteer Application

1000 Carondelet Drive, KCMO 64114 816-943-2775

Website: www.carondelethealth.org

General Information (Please Print)

First Name: _____ M.I. _____ Last Name: _____ Today's Date: _____
 Home Address: _____ City: _____ State: _____ Zip: _____
 Home Telephone: _____ Work Phone: _____ Cell or other Phone: _____
 Birth date: _____ Male/Female: _____ Social Security: _____ E-Mail: _____

Education

I have completed: 8 9 10 11 12 13 14 15 16 17 18 19 20

Name of School/University: _____

Major field of study: _____

Degree Attained: _____

Is volunteer service required for school credit? (Y) (N)

Current Employer

Company Name: _____ **Supervisor's Name:** _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Job Title: _____ Employment Dates: _____

Briefly describe previous work experience: _____

If you have relatives employed or volunteering at SJMC, please list here:

EMERGENCY CONTACT

Name	Relationship	Home Phone	Work Phone
Address	City	State	Zip

Name	Relationship	Home Phone	Work Phone
Address	City	State	Zip

Interests

How did you learn about SJMC Volunteer Program?

Why are you interested in volunteering?

List any disability that may limit the nature of your volunteer service:

Have you ever entered a plea other than "not guilty" or been convicted of a crime (Other than traffic violations) in the past? Yes ___ No ___ If "Yes", list all instances:

(Note: a "yes" response does not necessarily prevent you from volunteering at SJMC)

References (required)

Name	Address	City/State/Zip	Phone
1.			
2.			

References should not be relatives of the application

Authorization and Acknowledgment: (FOR STUDENTS 18 YEARS AND OLDER)

I authorize representatives of Carondelet Health to obtain a criminal background report and/or a motor vehicle driving record report and understand this consent is valid for the duration of employment. I release Carondelet Health as well as law enforcement authorities or other references from any liability as a result of their verification process.

Date _____ Signature _____

Applicant's Statement

If accepted as a St. Joseph Medical Center Volunteer, I agree that:

1. I shall hold as absolutely confidential all information that I may obtain directly concerning patients, residents, doctors, or personnel, and not seek to obtain confidential information for a patient.
2. My services are donated to the hospital without contemplations of compensation or future employment and given for humanitarian, religious or charitable reason.
3. I shall at all times uphold the Mission and Values of St. Joseph Medical Center.

I have read and understand each of the above conditions.

Signature of Applicant _____ Date: _____

Applicant Printed Name _____

CONSENT FOR MINOR TO PARTICIPATE IN VOLUNTEER ACTIVITES

This will authorize _____, a minor to participate in volunteer activities at St. Joseph Medical Center, as scheduled through the Coordinator of Volunteer Services.

I release the hospital and its employees from any claim of liability for any damages, injury or illness resulting to said minor, not occasioned by any fault or neglect on the part of the organization while participating in such volunteer services.

Should my child become ill or injured and our physician cannot be reached within a reasonable length of time, you have my permission to take appropriate action to see that she/he gets emergency care. This authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power to your organization.

Signature of Parent/Guardian

Date

Phone

Hospital Preference

Physician Name

Phone