INSPIRA MEDICAL CENTER MULLICA HILL
JUNIOR VOLUNTEER APPLICATION

The IMCMH Junior Volunteer Program is a SUMMER Program that begins in late June and concludes in late August. Upon completion of the program, there is an option to continue throughout the coming school year. Applications are accepted on a "first come/first serve" basis from December 1st to February 28th. Applicants must be 15 years old before the program starts in June.

Name:_____ Date:_____

(Last) (First)

Address:_____

(Street) (City) (State) (Zip)

Mother:_____ Father:_____

Address:_____ Address:_____

_____ _____

Cell Phone:_____ Cell Phone:_____

Alternate Phone:_____ Alternate Phone:_____

Email:_____ Email:_____

Applicant's Age:_____ Birth Date:_____ Grade in School:_____

School Name:_____ Phone:_____

Address:_____

Are you interested in a health career?_____ If so, what area?_____

If not, what is your ambition?_____

Do you know anyone who works or volunteers at this hospital?_____

If yes, who?_____

Your Doctor's Name:_____ Phone:_____

Address:_____

_____

Applicant's Signature

Many thanks for your interest in the Inspira Medical Center Mullica Hill Junior Volunteer Program and for completing this application. Please return in the envelope provided or send to:

Inspira Medical Center Mullica Hill
Attn: JrVol/MB
700 Mullica Hill Rd
Mullica Hill, NJ 08062

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To the parent or guardian of _____,

Your son or daughter has applied to be a Junior Volunteer at Inspira Medical Center Mullica Hill. As we are concerned about our patients' welfare as well as your child's well-being, we request health and school reports from your child's physician and guidance department.

Please sign the three attached permission slips so that we may proceed with the application procedure. All the information will be kept in strict confidence.

We are delighted to have your child apply and hope the experience is meaningful to him or her. Thank you for your cooperation.

My son or daughter has my consent to serve as a Junior Volunteer at Inspira Medical Center Mullica Hill.

Yes_____ No_____

_____
Signature, Parent or Guardian

I hereby authorize Dr. _____, my child's personal physician, to complete a medical clearance form and return it to the Volunteer Services Dept/Inspira Medical Center Mullica.

_____
Signature, Parent or Guardian

I hereby give my permission to my child's school to release information on my child as requested by the Volunteer Services Department of Inspira Medical Center Mullica Hill.

Name of School_____

Name of Guidance Counselor_____

_____
Signature, Parent or Guardian