

# INSPIRA MEDICAL CENTER MULLICA HILL

## JUNIOR VOLUNTEER APPLICATION

The IMCW 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 1<sup>st</sup> to February 28<sup>th</sup>. 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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## JUNIOR VOLUNTEER APPLICATION

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.

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

Yes \_\_\_\_\_ No \_\_\_\_\_

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Signature, Parent or Guardian

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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.

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Signature, Parent or Guardian

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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 \_\_\_\_\_

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Signature, Parent or Guardian