



Carolinah HealthCare System

Dear Teen Applicant,

Thank you for your interest in volunteering with Carolinas HealthCare System Central Division! The Central Division consists of Carolinas Medical Center, Carolinas Medical Center – Mercy, and Levine Children’s Hospital. Volunteers are an important part of our team and help us in many ways. We appreciate everyone who gives us the gift of their time. Wherever you volunteer, you will make a difference!

Below you will find a checklist of all the important documents required to complete your teen volunteer application. **ALL** items must be submitted **no later than** March 1st, 2018. Incomplete applications will not be considered.

The teen program will run from Monday, June 11th – Friday, August 10th. The majority of teen volunteer shifts are 2-4 hours in length, once per week. You will be required to commit to this minimum schedule. Teen volunteers will only be allowed to miss two shifts during the 9 week program. (**CMC-Mercy teen volunteers will be excused during the week of 4th of July*).

If your application is selected, you will be contacted for an in-person interview during the month of April. Once accepted into the program, you will also be required to complete a background check, Teammate Health Clearance (including a 2-step TB Skin Test), and attend a 3 hour volunteer orientation in May.

Because of the large volume of applications we receive, we are not able to accept everyone into our summer program. We appreciate your interest in volunteering at Carolinas HealthCare System and value your time in completing this application. **Please use the following checklist to complete your application:**

- Completed Teen Application
- TWO completed references from teachers or coaches
- Copy of most recent report card (must have GPA of 3.0 or higher)
- One-page essay answering this question: “How do volunteers impact the patient experience?”

Please return your completed application to the following address:

Carolinah Medical Center
Volunteer Services Department
1000 Blythe Boulevard
Charlotte, NC 28203
Fax: 704-355-7715
Email: CMCLCHVolunteerServices@carolinas.org

If you have any questions, please contact Vickie Hardin at 704-355-2105.



Carolinus HealthCare System

Teen Volunteer Application

(Please **print** legibly in black or blue ink)

Please select your location preference: (choose one)

_____ Carolinus Medical Center _____ CMC – Mercy _____ Levine Children’s Hospital

Personal Information:

Name: _____	Nickname: _____
Street Address: _____	
City: _____	State: _____ Zip: _____
Home #: _____	Cell #: _____
Email: _____	
What is the best way to contact you? _____	
Are you 15 or over? _____	Sex: Male Female

Education:

Circle the highest level of education completed :	8	9	10	11
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Emergency Contact Information:

Name: _____	
Relationship: _____	Home: _____
Work: _____	Cell: _____

Background Volunteer Experience:

Please list your previous volunteer experience, including the organization’s name and length of time with the organization:

Commitment Terms:

Teen volunteers are required to commit to a weekly volunteer shift that ranges from 2-4 hours in length, depending on department needs. Students may only miss 2 shifts during the summer session.

Please circle your availability below:

Monday	Morning	Afternoon
Tuesday	Morning	Afternoon
Wednesday	Morning	Afternoon
Thursday	Morning	Afternoon
Friday	Morning	Afternoon

Volunteer Agreement:

As a volunteer I agree:

I will consider as confidential all information which I may hear or see, directly or indirectly, concerning a patient, patient family member, doctor, or other health care professional and I will not seek information from any of the above in regard to a patient.

I hereby certify that the answers on this application and any resulting from interviews are true and correct and that any misrepresentations or omissions of facts, misleading, or false information on my part will be grounds for dismissal as a volunteer. Acceptance as a volunteer is contingent upon satisfactory references, verification of information submitted on the applications and satisfactory completion of mandatory requirements. I authorize that all employers, schools, or references thus contacted be released from all liability in answering questions related to my application.

I understand that I am required to commit to serve a regular schedule during the summer program. My services are donated to Carolinas HealthCare System without contemplation of compensation or future employment and given with humanitarian or charitable reasons.

I authorize Carolinas HealthCare System to administer emergency medical treatment to me while volunteering. I understand that Carolinas HealthCare System is not responsible for volunteers before or after their assigned shifts.

Applicant's Signature: _____ **Date:** _____

Parents of Teen Volunteers Applicants:

I give permission for my child to serve as a Teen Volunteer with Carolinas HealthCare System and authorize Carolinas HealthCare System to administer emergency medical treatment to my child while volunteering. **I understand that Teen Volunteers must be picked up promptly at the end of their scheduled shift and that CHS is not responsible for volunteers after their assigned volunteer shift has ended.**

Parent/Guardian Signature: _____ **Date:** _____

Background Disclosure:

CHS obtains arrest and conviction records on all potential volunteers. An arrest or conviction will not automatically eliminate you from consideration for volunteering. However, failure to list all pending charges and/or convictions may lead to you disqualification or termination of volunteering CHS. Examples include, but are not limited to: driving while impaired, worthless checks, assault, driving while license is suspended, disorderly conduct, credit card fraud, embezzlement, etc.

Have you ever been convicted of any criminal violation of law, or are you now subject to a pending investigation of charges for violation of criminal law?

No Yes: please explain: _____

TEEN SUMMER VOLUNTEER REFERENCE FORM

Please give this form to a teacher or coach who can attest to your character.

NOTE: This form is not to be completed by a relative of the Applicant.

Reference for _____
(Applicant's name)

INSTRUCTIONS: Please complete this form to the best of your ability. All references are kept confidential.

How long have you known the applicant? _____

In what capacity have you known the applicant? _____

What strengths do you believe the applicant will bring to our hospital as a volunteer?

Please place an 'x' in the appropriate box to rate the applicant on each of the following:

	Excellent	Very Good	Good	Fair	Poor
Interaction with other people					
Ability to follow through on commitment					
Ability to work independently					
Ability to take direction					
Verbal communication skills					
Overall attitude					

Additional comments:

Reference Information:

Your Name _____

Date _____

NOTE:

Thank you for taking the time to complete this reference form! Please return the completed form to the student applicant. They will need it to submit with their completed application. All applications are due to our office by March 1, 2018.



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