



Dear Prospective Youth Volunteer:

Thank you for your interest in the **Saint Luke's Health System Youth Volunteer Program!** We have an excellent program filled with a variety of opportunities for those 14-18 years of age.

To become a volunteer, you must complete the checklist below.

_____ **Prospective Youth Volunteer Profile** with parent/guardian signature.

_____ **Prospective Youth Volunteer Health Statement.**

_____ **Prospective Youth Volunteer Physician Form** with parent/guardian and physician signatures.

_____ **Volunteer Reference Forms (2).**

_____ **TB (tuberculosis) test/documentation.** Volunteers are required to submit TB test results/documentation (valid if within the last 12 months). The facility can administer the TB test at no cost. A TB test/documentation can also be obtained from your physician or Public Health Department. (parent/guardian permission required)

Please call the facility of choice to schedule an interview/orientation. The interview will include a discussion of the program, available opportunities, and expectations. A parent/guardian is encouraged to accompany you to the interview.

*Cabot Westside Health Center
2121 Summit
Kansas City, MO 64108
816/932-24481*

*Cushing Memorial Hospital
711 Marshall
Leavenworth, KS 66048
(913) 684-1104*

*Saint Luke's East
100 NW Saint Luke's Boulevard
Lee's Summit, MO 64086
(816) 347-4930*

*Saint Luke's Northland
5830 NW Barry Road
Kansas City, MO 64154
(816) 880-6083*

*Saint Luke's Plaza
4401 Wornall Road
Kansas City, MO 64111
(816) 932-2448*

*Saint Luke's South
12300 Metcalf Avenue
Overland Park, KS 66213
(913) 317-7405*

[information kept confidential]

PROSPECTIVE YOUTH VOLUNTEER PROFILE

SOCIAL SECURITY# _____ E-MAIL ADDRESS _____

NAME _____

(Last) (First) (Middle)
ADDRESS _____

PHONE (____) _____ DATE OF BIRTH _____ / _____ / _____ AGE _____ (14-18 yrs.)

FATHER _____ W.PHONE(____) _____ H.PHONE(____) _____

MOTHER _____ W.PHONE(____) _____ H.PHONE(____) _____

CURRENT SCHOOL _____ PHONE _____ LAST COMPLETED GRADE _____

ACTIVITIES _____

SKILLS Babysitting _____ Computer _____ Mentor _____ Other _____

AREAS OF INTEREST Clerical _____ Patient Contact _____ Errands _____ Nursing _____ Other _____

PREVIOUS WORK EXPERIENCE _____

PREVIOUS VOLUNTEER EXPERIENCE _____

HOW DID YOU LEARN ABOUT OUR VOLUNTEER PROGRAM? _____

DAYS/TIME AVAILABLE (Circle) S M T W TH F S Time (8-4, 8-12, 3-5, after school, other) _____

NAME OF PHYSICIAN _____ PHONE(____) _____

Please write a paragraph stating the reasons you want to volunteer. (for additional space use separate sheet)

PERSONAL REFERENCES: Please list two. (not relatives)

Name	Street Address	City	State	Zip	Phone
_____	_____	_____	_____	_____	(____) _____

Name	Street Address	City	State	Zip	Phone
_____	_____	_____	_____	_____	(____) _____

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YOUTH VOLUNTEER COMMITMENT:

As a Youth Volunteer for Saint Luke's Health System, I understand I will receive no remuneration for the services I provide. I will be assigned to a scheduled shift, and will be responsible for arriving and departing promptly. Should I be unable to do so, it is my responsibility to contact Volunteer Services. I agree to give service on the basis agreed upon and to maintain CONFIDENTIALITY concerning all customer information, adhering to the policies and procedures established by the facility. I understand SLHS facilities are tobacco free and acknowledge I can not smoke or use tobacco products of any kind on campus or on parking lots of the facility. I understand that failure to comply with these standards and the expected behavior of the Youth Volunteer Program will result in termination from my duties. I give permission to contact references.

YOUTH SIGNATURE: _____ **DATE:** _____

* * * * *

PARENT/GUARDIAN PERMISSION

In signing this document, I give permission for the youth named on this profile to participate in the Saint Luke's Health System Youth Volunteer Program and other facility sponsored activities. I verify the youth is 14-18 years of age and the information on this profile is correct. I understand that all of the profile packet's information will be kept confidential and is for office or emergency use only.

I am responsible for the purchase of a uniform (facility specific). I take responsibility for the youth's transportation, prompt arrival and departure for his/her scheduled shift. It is my responsibility to notify Volunteer Services of changes.

I give permission for the youth to receive a TB skin test which can be administered by the facility. I am responsible for the provision of a completed Health Statement. In the event of illness or injury and I am not available, the physician listed on this profile will be notified for treatment. Should the physician be unavailable, I give permission for the youth to receive appropriate emergency care.

DATE: _____ **PARENT/GUARDIAN:** _____
(required for students under age 18)

RELATIONSHIP: _____

NONDISCRIMINATION AND EQUAL OPPORTUNITY STATEMENT

*It is the policy of Saint Luke's Health System not to discriminate in admissions or access to, or treatment or employment in its program and activities, or in the granting, maintaining, upgrading and withdrawal of physician staff privileges for any unlawful reason, such as race, color national origin, sex, age, or handicap in violation of Section 504 of the Rehabilitation Act and applicable regulations.
Responsible employee: Administration Director of Civil Rights - 816-932-3820*

* * * * *

FOR OFFICE USE ONLY

INTERVIEW DATE/TIME _____ BY _____

Profile Received Health Statement 1 TB Test Screening 2nd Screening (as required)

Orientation/Video I.D. Badge Uniform/Shirt Received Fees Paid 1st 2nd Reference Received

Assignment _____ / _____ / _____
(day) (time) (position)

Start Date/Time _____

REMARKS: _____



PROSPECTIVE YOUTH VOLUNTEER HEALTH STATEMENT

(This section to be completed by Prospective Volunteer)

Prospective Youth Volunteer, Name

Physician, Name

- Check Facility:
- | | |
|--|---|
| <input type="checkbox"/> Cabot Health Center | <input type="checkbox"/> Saint Luke's Northland |
| <input type="checkbox"/> Cushing Memorial | <input type="checkbox"/> Saint Luke's Plaza |
| <input type="checkbox"/> Saint Luke's East | <input type="checkbox"/> Saint Luke's South |

Circle those that apply:

- | | |
|-----------------------------|-----------------|
| Allergies | Foot Problems |
| Hearing Problems | Arthritis |
| Heart Problems | Asthma |
| Hepatitis | Back Problems |
| High Blood Pressure | Diabetes |
| Tuberculosis | Fainting Spells |
| Other Infectious Conditions | Epilepsy |
| Mental Illness | |

Do you have any limitations, which would affect the type of volunteer position assigned? Yes No

If yes, please explain _____

List medications taken regularly: _____



YOUTH VOLUNTEER PERSONAL REFERENCE

Date _____

_____ has applied to volunteer at a Saint Luke's Health System facility and has given your name as a personal reference. Please complete this form and return to the youth. Thank you for your time.

Coordinator/ Youth Volunteers

VOLUNTEER REFERENCE

Name of Reference _____

Relationship to Applicant (not a relative) _____

How long have you known the applicant? _____

Is the applicant responsible/dependable? _____ Explain _____

Would you recommend the applicant as a volunteer at a Saint Luke's Health System facility? _____

Explain _____

Additional Comments _____

Signature of Reference _____ Date _____

Telephone #/ Email _____
(optional)



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Coordinator/ Youth Volunteers

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(optional)