



OhioHealth Riverside Methodist Hospital
3545 Olentangy River Road
Suite 114
Columbus, Ohio 43214

FOR OFFICE USE ONLY:

RECEIVED DATE: _____ INTERVIEW DATE: _____
ENTERED DATE: _____ ORIENTATION DATE: _____
ACKNOWLEDGED: _____ I.D. BADGE: _____
INTERVIEW CALL: _____ FLAG: _____

OHIOHEALTH RIVERSIDE METHODIST HOSPITAL
VOLUNTEER SERVICES
**HIGH SCHOOL
VOLUNTEER APPLICATION**

Today's Date: _____

LAST NAME		FIRST NAME	MIDDLE NAME	NICKNAME	HOME PHONE
ADDRESS					CELL PHONE
CITY, STATE, ZIP			E-MAIL ADDRESS		
BIRTHDATE (MINIMUM AGE REQUIREMENT - MUST BE 16 YEARS OF AGE) <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		SOCIAL SECURITY/TIN # (REQUIRED IN ORDER TO PROCESS APPLICATION)		DRIVER'S LICENSE #	
IF PRESENTLY EMPLOYED, NAME OF FIRM					HOURS PER WEEK
PLEASE CIRCLE WHICH ONE DAY OF THE WEEK YOU WILL VOLUNTEER Mon. Tue. Wed. Thurs. Fri. Sat. Sun. WHICH TIME OF THAT DAY DO YOU PREFER? <input type="checkbox"/> Mon/Fri 8:30 a.m. to 12 p.m. <input type="checkbox"/> Mon/Fri 12 p.m. to 5 p.m. <input type="checkbox"/> Sat/Sun 8:30 a.m. to 12 p.m. <input type="checkbox"/> Sat/Sun 12 p.m. to 4 p.m.					
HAVE YOU EVER VOLUNTEERED FOR THIS ORGANIZATION BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO			WHERE		WHEN
NAME OF HIGH SCHOOL		IS THIS A SCHOOL REQUIREMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		HOURS REQUIRED?	
OTHER VOLUNTEER EXPERIENCE? <input type="checkbox"/> YES <input type="checkbox"/> NO		WHERE:		WHEN:	
CONTACT IN CASE OF EMERGENCY: LAST NAME			FIRST NAME		
RELATIONSHIP	HOME PHONE		WORK PHONE		CELL PHONE
FAMILY PHYSICIAN					PHONE
NAME OF ANY RELATIVE CURRENTLY EMPLOYED BY OHIOHEALTH					RELATIONSHIP
ANY LIMITATIONS RELATED TO HEALTH? (VOLUNTEERS MUST BE ABLE TO PERFORM DUTIES INDEPENDENTLY)					
IF YES, ARE THERE ANY REASONABLE ACCOMMODATIONS THAT CAN BE MADE?					
SKILLS THAT YOU HAVE TO OFFER: EXAMPLE: PIANO, COMPUTER, ETC.					
TEEN'S SIGNATURE					DATE
PARENT'S SIGNATURE					DATE

BY SIGNING THIS VOLUNTEER APPLICATION (I/WE), THE PARENT(S) OR LEGAL GUARDIAN(S) OF THE ABOVE-REFERENCED MINOR AGREE AND ACKNOWLEDGE THAT (1) MY VOLUNTEER SERVICES ARE DONATED TO OHIOHEALTH RIVERSIDE METHODIST HOSPITAL ("RIVERSIDE") WITHOUT CONTEMPLATION OF COMPENSATION OR FUTURE EMPLOYMENT AND ARE GIVEN PURELY FOR CHARITABLE REASONS, (2) TO BE CONSIDERED FOR A VOLUNTEER PLACEMENT, I MUST COMMIT TO A MINIMUM OF ONE YEAR AND 100 HOURS OF SERVICES, (3) I AM CONSENTING TO ALL OTHER HEALTH ASSESSMENT OR SCREENING ACTIVITIES REQUIRED BY APPLICABLE LAW OR RIVERSIDE POLICIES. (4) RIVERSIDE MAY CONTACT MY PHYSICIAN REGARDING MY HEALTH STATUS, AND FORMS REQUIRED BY MY PHYSICIAN IN A TIMELY FASHION. (5) RIVERSIDE IS NOT OBLIGATED TO PROVIDE A VOLUNTEER PLACEMENT, NOR AM I OBLIGATED TO ACCEPT ANY VOLUNTEER PLACEMENT THAT IS OFFERED, AND (6) OPPORTUNITIES FOR VOLUNTEERS ARE PROVIDED WITHOUT REGARD TO RACE, COLOR, GENETIC INFORMATION, RELIGION, SEX, SEXUAL ORIENTATION, GENDER IDENTITY OR EXPRESSION, AGE, ANCESTRY, NATIONAL ORIGIN, VETERAN STATUS, MILITARY STATUS, PREGNANCY, DISABILITY, MARITAL STATUS, OR FAMILIAL STATUS FURTHERMORE, I RELEASE RIVERSIDE FROM ANY CLAIM OR LIABILITY OR ANY INJURY OR ILLNESS ARISING FROM MY PARTICIPATION IN ANY VOLUNTEER ACTIVITIES, AND UNDERSTAND THAT OHIOHEALTH RIVERSIDE METHODIST HOSPITAL IS NOT RESPONSIBLE FOR ANY RELATED CHARGES FROM ANY PHYSICIAN OR HOSPITAL, INCLUDING RIVERSIDE. LASTLY, I AGREE AND UNDERSTAND THAT THE ONLY WAY TO RECEIVE PAID EMPLOYMENT IS TO APPLY THROUGH THE HUMAN RESOURCES OFFICE AT 550 THOMAS LANE.

When completed, please mail these forms signed by the student and parent/legal guardian to the Volunteer Office: Volunteer Application, Volunteer Authorization for Background Check (3 sheets), Volunteer Commitment, Volunteer Dress Code, Parental Consent form along with your immunizations. You will be notified within one to three weeks after your application has been processed. We welcome your interest!