UNITYPOINT HEALTH- ALLEN HOSPITAL

READY TO VOLUNTEER?

STUDENT VOLUNTEER APPLICATION FORM

THE PROCESS

High school students are invited to apply for the SVP (Student Volunteer Program). Each May applications are accepted from interested students who will be attending high school the following August. Those students accepted into the program must have a keen interest in healthcare careers and strong desire to serve others. The SVP consists of opportunities for students to gain experience in a hospital setting. These experiences consist of serving others as volunteers as well as gaining healthcare career exploration. SVP takes place each summer during the months of June and July through mid-August.

We have 10 available spots for applicants for our SVP.
Summer Availability is as follows:

Monday-Friday we will have 1 student each day between the hours of 8AM-12PM and 1 student each day between the hours of 12PM-4PM.

With this new process, it will ensure everyone gets a chance to apply and be considered to be a student volunteer. We will also choose students that convey our FOCUS values, and will be a good fit for our department.

THE EXPECTATIONS

- Students must be at least 14 years of age

- Students must be in good standing with their school

- Students must have a letter of reference
(from an adult that is not a family member)

- Students must have their parents permission

- Students must commit to the full summer term (June-Mid August)

- Students may only have 3 unexcused absences. After the third absence, the student will no longer be able to volunteer.

- Students must comply with dress code, or will be asked to go home.

By signing below I agree to abide by the expectations and FOCUS values.

Student Signature

Parent Signature

Please save blank form to your laptop or PC. Email completed form to: Jennifer.Kipp@unitypoint.org

UnityPoint Health
Allen Hospital

Date received: _____
Date interviewed: _____
FOR OFFICE USE ONLY

Volunteer Application

Name (First, Middle, Last):	4-Digit PIN:	Birthdate:
Home Address (Street, Apartment Number):	Adult ☐ College ☐ High School ☐	
City, State, Zip:	Telephone No. Home/Work/Cell:	
Emergency Contact: Relationship and Phone Number: 1. 2.	Social Security # : Email:	

Physician: _____ City: _____

Work or Volunteer Experience
1.
2.
3.
4.
5.

References (Not Relatives)		
Name	Address, City, State, Zip	Telephone Number

Volunteer Areas of Interest:

_____

_____

_____

Do you have a record of founded child or dependent adult abuse or have you ever been convicted of a crime in this state or any other? ■ Yes ■ No

If yes, please specify: _____

Allen Hospital will consider all qualified individuals interested in contributing volunteer service without regard to race, religion, disability, color, age, sex or national origin.

Please Read

By signing below, I certify that the answers and information set out on the previous page are accurate and complete, to the best of my knowledge. I acknowledge that if any answer or information is not accurate, or complete, I may not be asked to provide volunteer services.

1. I authorize Allen Hospital to investigate all statements contained in this application for volunteer service, as well as my character and qualifications. I release Allen Hospital from all liability for acts performed in good faith and without malice in connection with the investigation of my background and evaluation of my application.

2. I authorize my past and present employers, volunteer organizations and others with information regarding my work, volunteering or my character to provide Allen Hospital with all information requested and to cooperate fully with the inquiry of my character qualifications. I also release those employers, references, and others from all liability for providing information in good faith and without malice.

3. I understand and agree that the relationship between myself and Allen Hospital may be terminated at any time by either party.

4. I understand that my acceptance to volunteer in patient contact areas depends on Allen Hospital ensuring that I have no health problems which would prevent me from volunteering effectively and with complete safety for myself and Allen Hospital patients, employees and visitors. Accordingly, I agree that if my health changes, I will submit a new medical clearance form from my physician and that my acceptance to volunteer will depend upon approval of Allen Hospital.

5. I understand that as a volunteer, I must conform to all Allen Hospital rules and regulations including those in the orientation manual. I also understand that I will be required to obtain and wear appropriate volunteer uniform. This uniform includes a name tag and a shirt, jacket or vest.

6. Please note that your volunteer commitment at Allen Hospital includes commitment to confidentiality. Names, diagnoses, and other patient/client information must not be shared. Discussing a patient/client or the patient's/client's condition is strictly prohibited and could create legal liability for Allen Hospital and you. This commitment to confidentiality extends to all communications taking place not only in the hospital but also outside the hospital.

7. I hereby give permission to Allen Hospital to conduct an Iowa criminal history and dependent/child abuse registry check with the Division of Criminal Investigation.

8. I understand and agree that if my photo is taken as an Allen Volunteer my photo may be used on social media or another marketing purpose.

Signature_____ Date_____

Please return completed form to Volunteer Services, Allen Hospital or email the completed form back to Jennifer Kipp at **Jennifer.kipp@unitypoint.org**