



We know children.

Teen Connection Volunteer Application

Children's Hospital & Medical Center
Volunteer Services
8200 Dodge Street
Omaha, NE 68114
(402) 955-4012

PERSONAL INFORMATION

Name: _____ Today's Date: _____

Address: _____
(Street Address) (City) (State) (Zip)

Home Phone: _____ E-mail: _____

Birth date: _____ High School: _____ Grade: _____

Year you plan to graduate: _____ Best time/day available to volunteer: _____

EMERGENCY CONTACTS

In case of an emergency notify:

(Name) (Relationship) (Home Phone) (Work Phone)

Who is your family physician? _____
(Name) (Address) (Phone)

VOLUNTEER INFORMATION

How did you hear about the Teen Connection volunteer program?

- Self Children's Volunteer Internet Friend Children's Employee
 Other _____

Name of individual who referred you: _____

Do you have to report these hours to anyone? _____ If so, whom & why? _____

Please list any activities that may interfere with volunteering? _____

Why do you want to volunteer? _____

Have you had any previous volunteer experience? _____

What experiences have you had working with children? _____

VOLUNTEER STATEMENT

I wish to donate my services to the Hospital and understand that there is no payment for my services rendered under the Volunteer program at Children's Hospital & Medical Center of Omaha. I am aware that my volunteer experience will not always involve direct patient contact. I agree to abide by the rules, regulations and policies of the Hospital and I shall work under the direction of the volunteer services staff and other Hospital staff as assigned. I also understand that I must maintain confidentiality regarding patient and family information. I further understand that if I do not abide by the rules, regulations, policies or break confidentiality, it may result in my termination from the Teen Connection Volunteer Program.

Volunteer Signature: _____ Date: _____

I have read and understand the above information and hereby give consent for my son/daughter to participate in the Teen Connection Volunteer Program at Children's Hospital & Medical Center of Omaha.

Parent/Guardian Signature: _____ Date: _____