330 Brookline Avenue, GZ/N – 210
Boston, MA 02215
(617) 667-3026

An Affirmative Action
Equal Opportunity Employer

APPLICATION FOR VOLUNTEER SERVICE
SUMMER HEALTH CORPS PROGRAM

Thank you for applying for a volunteer position with Beth Israel Deaconess Medical Center. We will make every effort to match your skills and interests with our available summer positions. Please assist us by completing this application as thoroughly as possible. We appreciate your interest in our organization. When we receive your application, we will call you for an interview and explain the process.

Date_____

Please Print Clearly

Name_____

Address_____
Street Town/City Zip Code

Volunteers must be at least 14 years old. Do you meet this requirement?
(Please circle) YES NO

_____ _____
Social Security Number Birth Month/Day/Year

Telephone Number _____ Email _____

Parent or Guardian _____

Emergency Telephone Number_____

School and Address _____

Guidance Counselor or Teacher_____Telephone_____

Work/Volunteer Experience _____

_____

_____

_____

Career Objective_____

Languages Spoken_____

Talents/Interests_____

Personal References: Applications **must include** two letters of reference on letterhead from persons who have known you for several years, (e.g. rabbi, priest, minister, physician, teacher, counselor or employer). Letters from relatives or personal friends are not acceptable.

Who referred you to BIDMC? _____

My answers to the questions above are true and complete to the best of my knowledge. I understand that if I misrepresent or withhold information, it may result in my application being rejected or dismissal if discovered after my volunteer assignment begins. The Medical Center may make inquiries regarding my history and character to prior employers, schools, etc. and I hereby release employers, schools, or individuals from all liability in responding to inquiries in connection with my application and release the Medical Center from all liability with respect to such inquiries. As a volunteer, I agree to abide by the Medical Center's policies, rules and procedures and understand that I may end my volunteer assignment at any time with or without cause or notice and the Medical Center has the same rights.

_____ _____

Date Signature

EMPLOYEE OCCUPATIONAL HEALTH SERVICE
CONSENT FOR PRE-PLACEMENT OCCUPATIONAL EVALUATION OF A MINOR

Completion of this form is required by all applicants under 18 years of age.

PLEASE PRINT

NAME OF APPLICANT_____

DATE OF BIRTH _____

POSITION APPLIED FOR_____

I give my consent and authorize Beth Israel Deaconess Medical Center to perform a Pre-Placement Occupational Screening on the above named applicant. A registered nurse, nurse practitioner, or a physician will perform the history and medical assessment. The screening will include blood tests, tuberculosis screening, and immunizations if needed. Additional testing may be required depending upon the work assignment.

If you have any records regarding immunizations, please have those records forwarded to the Employee Occupational Heath Service Office on Deaconess 1.

_____
Signature of Parent or Legal Guardian Date

_____
Address City State Zip

_____
Home Telephone Work Telephone