

**UNIVERSITY HOSPITALS PARMA MEDICAL CENTER  
JUNIOR VOLUNTEER APPLICATION**

*Please Print*

Name: \_\_\_\_\_  
(First Name) (Middle Initial) (Last Name)

Home Phone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street Address) (City) (Zip Code)

E-Mail Address: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

High School: \_\_\_\_\_ Year of Graduation: \_\_\_\_\_

Presently Employed? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, where: \_\_\_\_\_

Previous Volunteer Work? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, where: \_\_\_\_\_

List any Extra-Curricular Activities: \_\_\_\_\_

Days/Times Available to Volunteer: \_\_\_\_\_

.....  
**CONFIDENTIALITY:**

As a volunteer, you will be trusted to keep confidential any information you may learn about the patients you encounter. It is especially important that you respect the individuals' right to privacy and at no time reveal his or her identity, diagnosis, or care plan. Violation of patient confidentiality will result in termination of your volunteer services at University Hospitals Parma Medical Center.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**Junior volunteers must be at least 15 years of age and high school sophomores. A minimum of 50 hours in a given year is a requirement. You are expected to be here when you are scheduled.**

Please return the signed application, essay and 2 letters of recommendation by email to [GERALYN.NOVICKY@UHhospitals.org](mailto:GERALYN.NOVICKY@UHhospitals.org) or by mail to : Volunteer Services Department  
UH Parma Medical Center  
7007 Powers Boulevard  
Parma, OH 44129