



**Department of Volunteer Services  
716-898-3266**

Dear Prospective Volunteer:

Thank you for expressing an interest in becoming a Junior Volunteer at the Erie County Medical Center Corporation. **You must be 16 years old** to volunteer at ECMC. Enclosed is an application for you to fill out, a consent form for your parent(s) or guardian to sign and a recommendation form for your guidance counselor or favorite teacher to complete. It is also required that you submit working papers and an up-to-date immunization record.

When you are ready to submit these materials, please call to schedule an interview by calling (716) 898-3266. At the interview, we will discuss what you hope to gain from your volunteer experience and what volunteer opportunities are available.

I look forward to working with you to better serve the patients and families at ECMCC.

Sincerely,

Kathi Mitri

Volunteer Coordinator



The Junior Volunteer Program provides guidance and encouragement to high school students considering a career in health care. The Junior Volunteer gains educational rewards, as well as the personal satisfaction one receives from unselfish service to others.

Appropriate volunteer duties include: clerical work such as typing, filing, or receptionist duties; transporting patients; running errands for staff; assisting patients with crafts; or visiting patients. Other duties may include packing supplies, delivering flowers and mail, and reading to or offering companionship to patients.

### WHAT YOU NEED TO KNOW

- 1. You must be at least 16 years of age.**
2. Because you are under 18 years old working papers are required before you can start your assignment. Your school guidance counselor can provide you with an application for working papers.
3. An orientation will be held at the beginning of the program. You will be required to attend the orientation in order to participate in the program.
4. A minimum total of 25 hours is expected; you may give more time if you choose.
5. You will receive a uniform to wear while on duty. It is your responsibility to keep it clean and neat. You will be issued an ID badge that must be worn at all times.
6. Please dress professionally as you represent ECMCC to our patients, visitors and staff. Jeans, bare midriiffs, baseball caps, etc. are not permitted. The use of personal cell phones while on duty is not permitted.
7. Rubber soled shoes or sneakers are suggested. No open toe sandals or flip-flops are allowed.
8. Please be prompt and report for duty on the days you are scheduled. You may call the Volunteer Office at 898-3266 if you need to adjust your schedule.
9. At the end of the program, please let the Volunteer Coordinator know if your school will need verification of your volunteer hours.
10. When your volunteer service has been completed, please return your ID badge and your uniform to the Volunteer Coordinator.

Thank you in advance for your service to the patients, families and staff  
of the Erie County Medical Center Corporation

Health Assessment \_\_\_\_\_  
Orientation \_\_\_\_\_  
Start Date \_\_\_\_\_  
Location \_\_\_\_\_



CORPORATION

Department of Volunteer Services  
716-898-3266

### Junior Volunteer Application

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_ City/Town/State: \_\_\_\_\_

Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: M  F

Parent or guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
(if parent or guardian cannot be reached)

Relationship: \_\_\_\_\_

Are you 18 years old or older?

Yes  No

If no, what is your birth date?

Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

Do you have working papers?

Yes  No  Please attach copy but will submit prior to beginning work

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Are you volunteering to fulfill a school requirement?

Yes No If yes, number of hours needed \_\_\_\_\_ Name of school contact person: \_\_\_\_\_

Phone: \_\_\_\_\_

Please answer the following questions:

Why are you interested in volunteering at ECMCC? \_\_\_\_\_

If you are interested in a particular area or assignment, please indicate your preferences: \_\_\_\_\_

Are there any physical limitations that might affect your volunteer work? \_\_\_\_\_

Please list previous volunteer experience or any organizations to which you belong: \_\_\_\_\_

Do you have any special interests, hobbies, or talents? \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Your Signature:		Date:	
-----------------	--	-------	--



Department of Volunteer Services
716-898-3266 / fax: 898-4358

Dear Health Care Provider:

As a requirement for volunteering in a health care facility in New York State, each prospective volunteer must meet pre-employment health standards. Kindly complete and sign this form for your patient. Thank you, Kathi Mitri, Volunteer Coordinator

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

1. Is this person in general good health and free from communicable disease?

2.

Yes [ ] No [ ] (Please comment on reverse side)

3. Date of last exam: \_\_\_\_\_

4. Rubella immunization Date: \_\_\_\_\_
or

Rubella antibody test results: \_\_\_\_\_ Date: \_\_\_\_\_

5. Rubeola (measles) immunization dates: 1st: \_\_\_\_\_ 2nd: \_\_\_\_\_
or

Rubeola (measles) antibody test results: \_\_\_\_\_ Date: \_\_\_\_\_

5. Mumps immunization Date: \_\_\_\_\_ 2nd \_\_\_\_\_
or

Mumps antibody test results: \_\_\_\_\_ Date: \_\_\_\_\_

6. Varicella immunization Date: \_\_\_\_\_ 2nd \_\_\_\_\_
or

Varicella antibody test results: \_\_\_\_\_ Date: \_\_\_\_\_

7. TB skin test (PPD):

Date: \_\_\_\_\_ Type: \_\_\_\_\_ Results: \_\_\_\_\_

or

[ ] Known prior positive test; PPD skin test not performed. Chest X-ray WNL. No signs and symptoms of active TB.

8. Diphtheria/tetanus Date: \_\_\_\_\_

9. Influenza Vaccine Date: \_\_\_\_\_ Lot # \_\_\_\_\_ Expiration Date: \_\_\_\_\_

10. OPTIONAL

Hepatitis B vaccine Dates: 1st: \_\_\_\_\_ 2nd: \_\_\_\_\_ 3rd \_\_\_\_\_

Other (Specify): \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Examining Provider: \_\_\_\_\_

Print or Stamp Name: \_\_\_\_\_ Date: \_\_\_\_\_



**JUNIOR VOLUNTEER PROGRAM  
PARENT PERMISSION FORM**

**Department of Volunteer Services**

**716-898-3266**

My son/daughter \_\_\_\_\_ has my permission to serve as a Junior Volunteer at the Erie County Medical Center Corporation and is physically able to do so.

I understand that my child's eligibility for the Jr. Volunteer Program is contingent on his/her good health. I further understand that it is my responsibility to arrange for my child's transportation to and from the Medical Center.

**Signature of Parent or Legal Guardian** \_\_\_\_\_

Relationship \_\_\_\_\_ Date \_\_\_\_\_



**JUNIOR VOLUNTEER PROGRAM  
SCHOOL RECOMMENDATION  
716-898-3266/fax: 898-4358**

**Department of Volunteer Services**

STUDENT'S NAME \_\_\_\_\_

SCHOOL \_\_\_\_\_

	GOOD	AVE	BELOW AVERAGE	NOT ABLE TO EVALUATE
Willingness to learn	_____	_____	_____	_____
Ability to complete assigned duties	_____	_____	_____	_____
Responsibility	_____	_____	_____	_____
Dependability	_____	_____	_____	_____
Interpersonal Skills	_____	_____	_____	_____
Empathy for Ill/Handicapped Individuals	_____	_____	_____	_____
Honesty	_____	_____	_____	_____
Maturity	_____	_____	_____	_____
Personal Appearance/Grooming	_____	_____	_____	_____
Willingness to follow rules	_____	_____	_____	_____
Ability to follow instructions	_____	_____	_____	_____

What are this student's greatest strengths, abilities and talents?

What problem areas might impact on this student's performance as a Jr. Volunteer?

In 2-3 sentences, how would you discuss this student's motivation for volunteering and ability to contribute to our program?

SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_

SCHOOL \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_

DATE \_\_\_\_\_