Piedmont COLUMBUS REGIONAL

AUXILIARY

Today's Date: _____

RETURNING VOLUNTEER? ____ Yes ____ No

Former placement(s)_____

Last Name: _____ First Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Youth Cell #: (_____) ____ - _____ Youth Email: _____

We will use this email to contact you regarding your application and interview.

Birthdate: ___/___/___ Age:_____ School:_____ Grade: _____

Does your school require volunteer service hours? ____ Yes ____ No How many? _____

Uniforms: $35—full scrubs. Do not send money with application. You will purchase your uniform after you have been notified of selection. Your scrubs must be purchased through the Uniform Shop at **PCR Midtown campus by May 16th**. Limited assistance may be available on recommendation of counselor.

PARENT/GUARDIAN INFORMATION

Name: _____ Relationship: _____

Cell #: (____) ____ - _____ Alternative #: (____) ____ - _____ Email: _____

□ **This is my emergency contact.**

Name: _____ Relationship: _____

Cell #: (____) ____ - _____ Alternative #: (____) ____ - _____ Email: _____

□ **This is my emergency contact.**

Youth Volunteer shifts are Monday – Friday 9:00 AM – 3:00 PM. **THERE ARE NO EVENING OR WEEKEND SHIFTS.**

Piedmont
COLUMBUS REGIONAL
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Last Name: _____ First Name: _____

Photograph Release:

1. I hereby relieve and agree to hold Piedmont Columbus Regional Healthcare System, Inc. and its affiliated companies, free and harmless from any and all liability arising out of the interviewing and/or photographing and subsequent publication or broadcasting of such photography. I understand that the interviewing and/or photographs are being carried out with my authorization for the use indicated above and thereby, I assume full responsibility for any subsequent liability arising out of the use of these photographs.
2. I understand that I have a right to request cessation of recording or filming and I have a right to revoke this authorization in writing up until a reasonable time before the recording or film is used.

CONFIDENTIALITY STATEMENT

I understand and agree that, in the performance of my duties as a Youth Volunteer with Piedmont Columbus Regional, I must hold patient/medical information in confidence. Information should not be discussed with any individuals including co-workers, other volunteers, other students, or family. I also understand that any violation of patient confidentiality may result in termination from the Youth Volunteer Program.

Youth Volunteer Signature: _____ Today's Date: _____

By signing this application, I hereby certify that all of the information contained is true to the best of my knowledge. I also understand that my acceptance into this program hinges heavily, among other previously listed items, on my ability to commit to the volunteer timeframe outlined above.

Youth Volunteer Signature: _____ Today's Date: _____

Parent Signature: _____ Today's Date: _____

For questions: Nancy Williams (706) 571-1484 or nancy.williams@piedmont.org