1050 Division Street | Mauston, Wisconsin 53948
608-847-6161 | milebluff.com

MileBluff MEDICAL CENTER

Healthcare evolving for life

Application for Volunteer Services – Minor *(must be at least 14 years old)*

PERSONAL INFORMATION:

Last name: _____ **First name:** _____ **Middle initial:** _____

Home address: _____

City: _____ **State:** _____ **Zip code:** _____

Phone number: (_____)-_____-_____ **E-mail address** *(optional)*: _____

Date of birth: ____ / ____ / _____ **Expected graduation year:** _____ **School name:** _____

PREFERENCES AND QUALIFICATIONS:

I would be interested in volunteering at *(check all that apply)*:

- ☐ Crest View Nursing & Rehabilitation Center, New Lisbon
- ☐ Mile Bluff Medical Center, Mauston
- ☐ Fair View Nursing & Rehabilitation Center, Mauston

Days and times available *(check all that apply and provide times for each)*:

- ☐ Monday _____
- ☐ Tuesday _____
- ☐ Wednesday _____
- ☐ Thursday _____
- ☐ Friday _____
- ☐ Saturday _____
- ☐ Sunday _____

List school clubs and/or other activities: _____

_____

List special skills that could be helpful for volunteer work *(typing, special training, etc.)*: _____

_____

REFERENCES: *(non-family preferred)*

1. **Name:** _____ **Phone number:** (_____)-_____-_____

   Address: _____

2. **Name:** _____ **Phone number:** (_____)-_____-_____

   Address: _____

EMERGENCY CONTACT INFORMATION:

Name: _____ **Phone number:** (_____)-_____-_____

Relationship to you: _____

APPLICANT AUTHORIZATION:

I acknowledge that I have truthfully completed this application. If chosen for volunteer service, I agree to attend orientation *(as directed by the volunteer coordinator)* and to provide service on a regular basis as specified in my training. I agree to uphold the standards and values of Mile Bluff Medical Center, and to follow volunteer guidelines.

Applicant signature: _____ **Date:** ____ / ____ / _____

PARENT/GUARDIAN AUTHORIZATION:

I hereby provide permission for _____ *(hereafter referred to as my child)* to become a member of the volunteer program at Mile Bluff Medical Center. I also give permission for my child to undergo the two-step Mantoux (tuberculosis skin test) and immunization titer (blood test). I assume complete responsibility for any injury or damage sustained by my child during volunteer time, and release Mile Bluff Medical Center of any and all liability for such injury or damage. I also grant Mile Bluff permission to perform a criminal background check on my child, to ensure the safety of all of those entrusted to the care of Mile Bluff.

Parent/guardian name: _____ **Phone number:** (_____)-_____-_____

Parent/guardian address: _____

Parent/guardian signature: _____ **Date:** ____ / ____ / _____