

TEEN VOLUNTEER APPLICATION

GREENVILLE HEALTH SYSTEM
VOLUNTEER SERVICES DEPARTMENT



GREENVILLE
HEALTH SYSTEM

DESIRED VOLUNTEER LOCATION

- Greenville Memorial Medical Campus (Cancer Institute/Center for Family Medicine/Children’s Hospital/ Corporate Services/Cross Creek Surgery Center/Girls on the Run/Greenville Memorial Hospital/Life Center/ Marshall I. Pickens Hospital /Medical Center Clinics/Medical Offices/Peace House/Roger C. Peace Hospital)
Return to Volunteer Office at Greenville Memorial Hospital
701 Grove Road Greenville, SC 29605 (864) 455-7994 (864) 455-4182 fax

- Greer Medical Campus (Greer Memorial Hospital/Cottages at Brushy Creek/Medical Offices)
Return to Volunteer Office at Greer Memorial Hospital
830 S. Buncombe Road Greer, SC 29650 (864) 797-8072 (864) 797-8078 fax

- North Greenville Medical Campus (Medical Offices/North Greenville Hospital)
Return to Volunteer Services at North Greenville Hospital
807 North Main Street Travelers Rest, SC 29690 (864) 455-9237 (864) 455-9190 fax

- Patewood Medical Campus (Gardens at Eastside/Medical Offices/Outpatient Services/Patewood Memorial Hospital)
Return to Volunteer Office at Patewood Memorial Hospital
175 Patewood Drive Greenville, SC 29615 (864) 797-0112 (864) 797-1010 fax

- Simpsonville Medical Campus (Hillcrest Memorial Hospital/Medical Offices)
Return to Volunteer Services at Hillcrest Hospital
729 SE Main Street Simpsonville, SC 29681 (864) 454-6179 (864) 454-6116 fax

PERSONAL INFORMATION

Name: _____ E-mail: _____

Address: _____
Street City State Zip

Home Phone: (____) ____ - ____ Work Phone: (____) ____ - ____ Cell Phone: (____) ____ - ____

Date of Birth: _____ School: _____ Grade: _____

Mother’s Name: _____ Employer: _____

Business Address: _____

Business Phone: (____) ____ - ____ ext. ____ Cell Phone: (____) ____ - ____ E-mail: _____

Father’s Name: _____ Employer: _____

Business Address: _____

Business Phone: (____) ____ - ____ ext. ____ Cell Phone: (____) ____ - ____ E-mail: _____

(Application continued on back.)

PERSONAL REFERENCES: Please provide complete information.

Family Doctor: _____ Office Phone: (_____) _____ - _____

Office Address: _____
Street City State Zip

E-mail: _____ Fax: _____

School Counselor or Teacher: _____ School Phone (_____) _____ - _____

School Address: _____
Street City State Zip

E-mail: _____ Fax: _____

COMMUNITY ACTIVITIES/VOLUNTEER INFORMATION

Community/Volunteer Activities: _____

Skills/Hobbies/Special Interests: _____

Special Communication Skills (i.e. Sign Language, fluency in foreign languages): _____

Are you interested in a health care career? _____ If so, what area? _____

If not, what is your career ambition? _____

STATEMENT OF UNDERSTANDING

I hereby give Greenville Health System permission to contact the listed references and release Greenville Health System from any liability as a result of such contact.

I understand that volunteer placement will be contingent upon receipt of satisfactory references and a personal interview, a physician's release, completion of all initial and future health requirements as prescribed by Greenville Health System's Employee Health Department, a criminal background check, and completion of orientation and training requirements.

Signature of Applicant: _____ Date: _____

Please return to appropriate address as listed on the front no later than May 1.

(Applications cannot be accepted after May 1.)

Teens must be at least 15 years of age by June 1 to participate this year.

Departmental Use Only:

Date Application Received: _____

Doctor's Reference Sent: _____ Received: _____

School Reference Sent: _____ Received: _____