



Information for Completing the LAPS Junior Volunteer Application

(Note: Application must be completed and submitted to LAPS by ALL applicants to the LAPS Summer Program at LAC + USC, even those that are CURRENTLY LAC + USC volunteers)

*Please note: A few sections of the application have already been filled in to comply with the LAPS Eve & Gene Black Summer Medical Career Program requirements.

- Application must be hand **signed in blue ink** by the applicant.
- Application must be hand **signed in blue ink** by parent or legal guardian.
- Application must be hand **signed in blue ink** by school counselor.
- Applicant must reside in Los Angeles County.
- Applicant must provide a social security number. (If selected, this number is needed for clearance process at LAC+USC. If not selected, all applicant information is shredded.)
- The requirement for a letter of recommendation and a current grade report will be fulfilled by submitting the required documents with your application for the LAPS Eve & Gene Black Summer Medical Career Program. On the LAC+USC application, page 2, you will need to fill in the name of the person who has supplied your letter of recommendation. (GPA must be 2.5 or over)
- The LAPS Eve & Gene Black Summer Medical Career Program is preapproved for 160 hours of volunteer service, so that the minimum commitment of 200 hours does not apply.
- Applicant, after selection by LAPS, will need to attend a mandatory 8 hour Saturday General Orientation and Department Specific Training.
- Applicant, after selection by LAPS, must be able to provide Parent consent for Live scan fingerprints- Parents must have a valid identification
- Applicant, after selection by LAPS, must be able to complete and clear the background check by the Department of Justice (DOJ) through the LAC+USC Medical Center Human Resources Department.
- Applicant, after selection by LAPS, must be able to clear Health Clearances from LAC+USC Medical Center – Employee Health Services or Submit Health Clearance information including TB test, immunizations.

LAC+USC MEDICAL CENTER "
*******Xolunteer Service Department"**
'3422'N.'State Street,'IPT,'1st Floor,'Room 1K311
*******Los Angeles, CA 90033**
******Telephone(323) 409 -6945**

****OFFICE USE ONLY

Vol. # "

JUNIOR VOLUNTEER APPLICATION

1. Name -Last		First	Middle	Social Security #	Sex F <input type="checkbox"/> M <input type="checkbox"/>		Birth date		
2. Address Number Street		Apt. #	City		State	Zip Code			
3. your cell phone number		Parents cell phone #		Parents E-Mail	Volunteer	E-mail address			
4. Parent/Legal Guardian Name			Parent /Legal Guardian Address			Daytime telephone			
5. Medical Insurance Name & Policy Number			Physician's Name			Phone Number			
6. Name of School Presently Attending -			Address		Grade	GPA	Graduation Year		
7. Previous Volunteer Experience and duties completed			8. Does someone you know work/train or volunteer at LAC+USC Medical Center? Yes No Name _____ relationship to you _____						
9. Hobbies/sports			10. What career are you interested in ?						
11. Personal talents/skills			12. When you think about volunteering, what type of things interests you?						
13. School Activities presently involved with:			14. Why do you want to volunteer at this hospital?						
15. What areas would you like to volunteer in? Circle ONE a. Child care b. Patient Care Units c. Office/Clerical d. Clinics e. Guest services f. Ehops			16. What do you hope to gain from your volunteer experience?						
17. What days and times are you available? You may only volunteer during office hours: 7:30 a.m. - 6:00 p.m. Mon - Fri & Sat 7:30 a.m - 4:00 p.m. Must be available a minimum of one 4 hour shift per week or two 2 hour shifts per week			Days	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
			Time	8 am to 5 pm daily Mon. through Fri.					

As Junior Volunteer I understand that I am required to be a student between the ages of 14 and 17 1/2

- Have a written consent from a parent or guardian.
- Provide a copy of my most recent report card with a GPA of 2.5+ with Gene Black program application
- Have this application signed by my school counselor and include a recommendation letter completed by _____ of person making the recommendation (with Gene Black program application)
- Follow the hospital rules and regulations as specified on the Volunteer Agreements
- Contact the Volunteer Coordinator immediately prior to any need to absences from my volunteer assignment.
- Volunteer a minimum of 200 hours total with a minimum of 4 hours per shift per week. (N/A- with Gene Black program)

Signature of Applicant

Date

PARENT AUTHORIZATION TO PARTICIPATE AND MEDICAL RELEASE

This authorizes _____ to participate in volunteer activities at LAC+USC Healthcare Network directed by the Hospital's Department of Volunteer Services. The LAC+USC Healthcare Network is release from any liability for any illness or injury resulting to said minor while participating in such volunteer activities when it does not result from fault or neglect on the part of the Medical Center. I give permission for my child to have a semiannual TB test or annual Chest X-ray (if necessary), and blood test for rubella, measles, and chickenpox. I give permission for my child to have emergency treatment in the case of an accident or injury while on duty at LAC+USC Medical Center.

Print Name _____

Parent/guardian signature _____ Date _____

Relationship to minor (Parent or Legal Guardian) _____

Emergency Contact: _____ Phone Number: _____
(Relationship to minor)

Este documento autoriza a _____ a participar en actividades del departamento de Voluntarios. El Centro Medico LAC+USC se exime de toda responsabilidad por enfermedad o lesiones causadas a dicho (a) menor mientras participa en dichas actividades voluntarias cuando estas no resulten por culpa o descuido de parte del Centro Medico. Doy mi permiso para que mi hijo/hija se someta a una prueba de tuberculosis o Rayos X del pecho (si fuese necesario), y una prueba de sangre para detectar si tiene antivirius de la rubéola, sarampión y varicela. Doy me permiso/autorización para que le den tratamiento medical de emergencia en caso de accidente o lesiones mientras este prestando servicios voluntarios en el Centro Medico LAC+USC.

Imprima el Nombre _____

Firma _____ Fecha _____

Relación/parentesco con el menor (padre o tutor) _____

Nombre de persona en caso de emergencia: _____ Telefono#: _____
(Relacion con el menor)

FOR USE BY HIGH SCHOOL CAREER COUNSELOR ONLY

Grade Point Average (must be a minum of 2.5) _____

Counselor's Signature _____ Date _____

School Name: _____

Phone Number: _____ Ext.: _____

FOR OFFICE USE ONLY			
	Date	BY	Comment
Application reviewed & Accepted	_____	_____	_____
Interview Scheduled	_____	_____	_____
Orientation	_____	_____	_____
Livescan FP/ EHCclearance	_____	_____	_____