2023 - 2024 Student Volunteer Application Information Sheet

The Student Volunteer Program is for high school students that are interested in volunteering at Backus Hospital during the school year. The program follows the academic calendar and schedules will be based off of your availability.

If you have questions about our program, please contact Volunteer and Guest Services at backus.volunteers@hhchealth.org.

THE PROCESS – APPLICATION FORM

• Applicant completes the Student Volunteer application in full
• Clearly print your e-mail address. We will use this regularly to communicate with you!
• Parent or guardian signs this application, which gives the hospital permission to contact the teacher or guidance counselor chosen for required reference
• Attach a photocopy of the student’s high school ID (transcript is acceptable if no student ID)
• Only complete applications filled out by the applicant will be considered

COLLEAGUE HEALTH REQUIREMENTS
For the safety of our volunteers and patients, we require healthcare provider documentation of the following:

• First and second MMR (measles, mumps, rubella) vaccinations, and
• First and second Varicella inoculations or date of disease
• Completed COVID-19 vaccinations
• Complete annual Flu shot if here during Flu season.

Please submit this documentation at the time of application.

APPLICANT INTERVIEW
We request that a parent or guardian be present to gain an understanding of our program. Be your best; we aim to make this interview as meaningful as possible, and encourage participants to be prepared.

REQUIREMENTS FOR THOSE ACCEPTED INTO THE PROGRAM

• Provide the results of a Tuberculosis test. If you are accepted into the program, there will more information to follow on how to complete the test
• Attend a 2-hour in-person orientation
• Commit to a minimum of 4 hours per week to volunteer. Please keep in contact with the supervisor(s) on schedule changes, or inability to work a scheduled shift
Student Volunteer Program FAQs:

**When are applications due?**
Applications are accepted throughout from August to February. We will stop accepting Student Volunteer Applications at the beginning of February, when we start accepting Junior Volunteer Summer Bridge Program Applications. Applications may be mailed to Backus Hospital Volunteer Services, emailed to Backus.Volunteers@hhchealth.org, or dropped off at the Backus Hospital main entrance and given to the Information Desk staff.

**Why do you need a photocopy of my high school ID?**
The photocopy of your high school ID is used to confirm your enrollment and your identity. A copy of your transcript will be sufficient in the event your school does not issue IDs.

**Can I pick what day I volunteer? Can I switch what day I volunteer each week?**
We do ask that you commit a minimum of 4 hours per week to volunteer. Your volunteer schedule will be based off of your availability, though there is value to consistency. This program follows the academic calendar, September through June.

Remember:
- Only complete applications filled out by the applicant will be considered.
- Make sure all required medical documentation, ID photocopy, and signature/initials are included.
- We will contact you via email and USPS mail, so please write legibly.
- The program follows the academic calendar and start dates will vary depending on applicant.
Student Volunteer Application (follows academic calendar)
To be completed by applicant

Applicant Information (Must be a High School Student)
Name: __________________________________________ Date of Birth: ____/____/____
Mailing Address: ____________________________________________________________
City/State/ZIP Code: _________________________________________________________
Preferred Phone Number: ____________________________ Email: ______________________
☐ Cell ☐ Home
Print legibly. We will contact you via email.

School Information
High School: ___________________ High School Grad Year: 20____
Mailing Address: ____________________________________________________________
City, State, ZIP Code: ______________________________________________________

Reference: Teacher or Guidance Counselor: ____________________________
E-mail address: ___________________________________________________________
* letters of recommendation will be accepted as well.

Health:
Do you agree to provide verification of 1st and 2nd MMR inoculations or titer? Yes ☐ No ☐
Do you agree to provide proof of 1st and 2nd varicella vaccinations, titer or
physician-documented date of disease? Yes ☐ No ☐
Do you agree to have mandatory Tuberculosis tests? Yes ☐ No ☐
Do you agree to have a mandatory COVID-19 and flu vaccinations? Yes ☐ No ☐

I understand my son/daughter ______________________, if accepted, is committing to volunteer at least one four-
hour day per week at Backus Hospital and give my permission to him/her to participate in all aspects of this
program. I also give permission for Backus Hospital to contact the school reference listed above.

Parent and Applicant Initials ______ ______

Email, hand deliver or mail to:
Volunteer and Guest Services
Backus Hospital
326 Washington Street
Norwich, CT 06360
Backus.Volunteers@hhchealth.org

Signature of Parent/Guardian

Print Name of Parent/Guardian

Preferred phone ☐ Cell ☐ Home

E-mail address

Address

City/State/ZIP code