# Terrebonne General Medical Center
# STUDENT VOLUNTEER APPLICATION

Name: _____ Date:_____

Address:_____
Street City State / Zip

Phone:_____ Cell Phone:_____

Are you under the age of 18: ( Yes / No ) If yes, how old are you:_____

Name of School:_____ Expected graduation date:_____

Career/ Area of Interest:_____

Emergency Contact Person:_____
Name Relationship Phone

Family Physician:_____Phone:_____

Are you physically able to perform the job duties associated with the position you are applying for? _____
_____

**Volunteer Experience**

| Institution | Address | Phone Number | Dates |
|---|---|---|---|
| | | | |
| | | | |

**References**

| Name | Address | Phone Number |
|---|---|---|
| | | |
| | | |

Applicant Signature:_____Date:_____

Parent Signature:_____Date:_____
(only applicable if under the age of 17)

Opportunities for volunteers are provided without regard to race, color, sex, age, religion, national origin, marital status, sexual preference/orientation, qualified disability and veteran status.