

Schreiber Pediatric Rehab Center Volunteer Application

Revised March 2016

Name	Birthday (month/date) i.e. October 11				
Address - include street, city, zip					
Home phone	Cell				
Email address					
Current school/employer					
Education – highest level completed	8	9	10 11 12	Some college	College degree
Previous volunteer experience					
EMERGENCY CONTACT – include name, address and phone					
Name			Phone		
Address					

AREAS OF INTEREST – CHECK ALL THAT APPLY		<input type="checkbox"/> Wherever you need me
<input type="checkbox"/> Preschool	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> Bumper Bowling	<input type="checkbox"/> Speech	<input type="checkbox"/> Clerical
<input type="checkbox"/> Special Events	<input type="checkbox"/> Gardening/ Landscaping	<input type="checkbox"/> Daycare
<input type="checkbox"/> Speech therapy		
School requirement: College level_____ High school level_____ Home school_____ Middle school_____		
# of hours needed_____ Shadow_____ Observation_____ Other_____		

Times	Mon	Tue	Wed	Thur	Fri	AVAILABILITY – Check all that apply
8am-12pm						
12pm-4pm						
4pm-7pm						

Have you been arrested or convicted of any criminal act more serious than a traffic violation? Yes No

I understand that this is an application and not a commitment or promise of volunteer opportunity.

Please be advised that some positions may require the volunteer to produce current copies (within one year of date) of the *PA Child Abuse History* and *Criminal Record History* clearances.

I give my permission to be photographed, videotaped, audiotaped or interviewed while at the Center. This material may be used for future publicity of Schreiber including for use by the news media.

Signature of volunteer Date

Signature of parent/guardian required for volunteers **under the age of 18** Date

Return completed application to: Alexa Smith, Interim Volunteer Coordinator, SPRC, 625 Community Way, Lancaster, PA 17603

asmith@schreiberpediatric.org

717-393-0425 x 129

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CONFIDENTIALITY AND SECURITY OF HEALTH RELATED INFORMATION NOTIFICATION AND ACKNOWLEDGEMENT

I have read Policy 502 – Notice of Privacy Practices and Policy 127 – HIPAA Confidentiality and Security of Protected Health Information Compliance and have had an opportunity to have my questions answered regarding the Center’s Confidentiality and Security of Protected Health Information policy. Confidential information, whether written, verbal, film, or electronic media, may be used or disclosed in a manner, which complies with these policies. I understand that I must comply with these policies and that failure to do so in any way will subject me to disciplinary action, up to and including termination of employment or opportunity to volunteer my services at the Center.

Print Name

Signature

Position

Department/Program

Date