



**Junior Volunteer Summer Program  
July 7 – August 26, 2022**

(ALL forms must be completed and returned by June 17, 2022)

1. You must be 14 years of age and completed 8th grade by July 1, 2022, TO APPLY.
2. Complete the Junior Volunteer Application including the agreement on the back of the application signed by you and your parent or guardian and return by **June 17, 2022** to:

Judy Villani, Director of Volunteer Services  
Niagara Falls Memorial Medical Center  
621 Tenth Street  
Niagara Falls, NY 14302

(Application may be faxed: 278-4614 or emailed: [judy.villani@nfmhc.org](mailto:judy.villani@nfmhc.org))

3. Give the Junior Volunteer Reference Form to your school counselor to complete. Your school counselor must send or fax the form to the Volunteer Office by **June 17, 2022**.
4. I will schedule an appointment, ***if necessary***, for an interview for **new volunteers** in the Volunteer Office in June. Interviews will last 15 minutes. No interviews will be given without an appointment. Please do not hesitate to call me if you have any questions.
5. Please have your family doctor complete the enclosed health form and return it with the completed application. You are required to have two measles, mumps, and rubella (MMR) inoculations, and a Diphtheria-Tetanus (within the last 10 years) **prior to volunteering**. You may get these inoculations from your doctor or from the health department. This is a New York State Health Department regulation and a Niagara Falls Memorial Medical Center policy.

**Junior Volunteer Orientation will be held on  
Wednesday, June 29th @ 10am**

**This orientation is REQUIRED for all new volunteers.**

**PLEASE NOTE:** *Acceptances are based on the recommendation of the school counselor and good citizenship.*



## JUNIOR VOLUNTEER APPLICATION

Print Name: \_\_\_\_\_

Telephone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Parent's Name: \_\_\_\_\_ Parent's Work Phone: \_\_\_\_\_

School: \_\_\_\_\_ Graduation Year: \_\_\_\_\_ Grade Completed 6/22: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**Director of Volunteer Services determines assignments based upon the needs of NFMCC.**

**Day(s)** (Please circle day & time you wish to volunteer)  
Sunday    Monday    Tuesday    Wednesday    Thursday    Friday    Saturday  
**Time(s)** 9am-12noon    12noon – 3pm    1pm-4pm    3pm-8pm

**Areas of Interest (Please check):**

- \_\_\_\_\_ Finance: 9:00 – 12noon and/or 12noon - 3:00pm (Monday – Friday only)
- \_\_\_\_\_ Patient Transport (Escort): 9:00 – 3:00 (Monday – Friday only)
- \_\_\_\_\_ Occupational/Physical Therapy: 9:00 – noon & 1-4 (Monday – Friday only)
- \_\_\_\_\_ Nursing Unit – Hours & days flexible 9:00am – 8pm all week
- \_\_\_\_\_ Office Clerical: 9:00 - noon and/or 12:30 – 3:30 (Monday – Friday only)
- \_\_\_\_\_ Pharmacy: 9:00 – noon and/or 12:30 – 4:30 (Monday – Friday only)
- \_\_\_\_\_ Gastro: 7:30 – noon and/or noon – 2:00 (Tuesday & Thursday only)
- \_\_\_\_\_ Surgery & Recovery: 9:00 – noon and/or 12:30 – 3:30 (Monday – Friday only)
- \_\_\_\_\_ Nursing Home Activities: 9:15 – noon and/or 1:15 – 3:30 (all week)
- \_\_\_\_\_ Other: (please add a choice not listed) \_\_\_\_\_

Please state briefly why you wish to become a Junior Volunteer:

*If accepted as a Medical Center volunteer, I agree that:*

1. I shall hold as absolutely confidential all information that I may obtain directly or indirectly concerning patients, doctors, or personnel, and not seek to obtain confidential information from a patient.
2. My services are donated to the Medical Center without expectation of compensation or future employment and given with humanitarian, religious, or charitable reasons.
3. I shall not sell or attempt to sell goods or services, request contributions, or solicit persons to sign political petitions on Medical Center premises unless I receive the express authorization of the **Director of Volunteer Services** to engage in these activities.
4. **I shall submit to a TB skin test (PPD). I understand that there is no cost to volunteers for this service. I hereby authorize person(s) making tests to report the results to the Medical Center.**
5. I shall be punctual and conscientious; conduct myself with dignity, courtesy, and consideration of others and endeavor to make my work professional in quality.
6. I shall attempt to resolve any problems related to my volunteer activities with my department supervisor or with the **Director of Volunteer Services**.
7. I shall make my best effort to fulfill my commitment to the Medical Center by completing all assignments I accept.
8. I shall at all times uphold the philosophy and standards of the Medical Center.
9. I understand that the Volunteer Services Department reserves the right to terminate my volunteer status as a result of:
  - A) Failure to comply with Medical Center policies, rules, and regulations.
  - B) Absences without prior notification.
  - C) Unsatisfactory attitude, work, or appearance.
  - D) Any other circumstances which in the judgment of the Director of Volunteer Services would make my continued service as a volunteer contrary to the best interests of the Medical Center.
10. **No cell phones or other computer devices are to be used in a NFMMC department when volunteering.** Niagara Falls Memorial Medical Center (NFMMC) is not responsible for any lost or stolen personal items.

*I have read each of the above conditions and agree to be bound by them.*

Junior Volunteer Signature: \_\_\_\_\_ Date \_\_\_\_\_

Volunteer Parent Signature: \_\_\_\_\_ Date \_\_\_\_\_  
(If volunteer is under age 18)

This signature also provides approval to administer the PPD (TB) skin test.



**To:** School Counselors  
**From:** Judy Villani, Director of Volunteer Services  
**Re:** Junior Volunteer Reference Forms

Each applicant for our **Junior Volunteer Program** has been asked to notify your office of his or her interest in being a junior volunteer. Please complete and return this form for each potential volunteer. You may mail or fax the form. Thank you for your cooperation.

Student's Name: \_\_\_\_\_

School: \_\_\_\_\_

Please rate the student on a scale from 1-10 in the following areas:

	<u>Poor</u>	<u>Average</u>	<u>Outstanding</u>
1. Good attendance/reliability	1 2 3	4 5 6 7	8 9 10
2. Sense of responsibility	1 2 3	4 5 6 7	8 9 10
3. Ability to follow directions	1 2 3	4 5 6 7	8 9 10
4. Consideration of others	1 2 3	4 5 6 7	8 9 10
5. Neatness	1 2 3	4 5 6 7	8 9 10
6. Good manners/discretion	1 2 3	4 5 6 7	8 9 10

Highly recommended: \_\_\_\_\_

Recommended with the following reservations: \_\_\_\_\_

Not recommended (explain): \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(School Counselor)

**Return to:** Judy Villani - Director of Volunteer Services  
Niagara Falls Memorial Medical Center  
621 Tenth Street  
Niagara Falls, NY 14302  
FAX: 278-4614



Volunteer Services Department  
621 Tenth Street  
Niagara Falls, NY 14302  
Phone: (716) 278-4440 Fax: (716) 278-4614

## Junior Volunteer Health Form

### DOCTOR OR HEALTH SERVICES NURSE SECTION

Dear Doctor or Health Services Nurse:

The New York State Health Department and Niagara Falls Memorial Medical Center (NFMMC) policy require that we have the following medical history recorded for each volunteer before he/she becomes an active volunteer. As an active volunteer, he/she may be assigned to work directly with patients and could be performing a variety of tasks. These tasks may include pushing patients in wheelchairs & carts, lifting moderate loads, running errands, standing or sitting.

**This section must be completely filled out by the applicant's doctor or nurse** to ensure that the volunteer (applicant) is free of communicable diseases, and that the applicant is physically able to perform the tasks outlined. **All information is required to volunteer at NFMMC.**

Applicant's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

The applicant is in general good health and is free from communicable disease? \_\_\_ Yes \_\_\_ No

If no, please explain: \_\_\_\_\_

List any restrictions: \_\_\_\_\_

Two MMR inoculations are required for anyone born since January 1, 1957. If two MMR inoculations were not given, please provide other proof of immunity:

Date of first MMR: \_\_\_\_\_ (after 12 months of age)

Date of second MMR: \_\_\_\_\_

Other proof of immunity: \_\_\_\_\_

Date of last Diphtheria-Tetanus (must be within last 10 years): \_\_\_\_\_

Applicant has had CHICKENPOX? \_\_\_ Yes \_\_\_ No \_\_\_ Unknown

Doctor or Health Services Nurse Signature: \_\_\_\_\_

Print name of person completing the form: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

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Niagara Falls Memorial Medical Center  
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