

Volunteer Application
Junior Auxiliary
Galion Community Hospital

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

School _____ Grade _____

Phone ___(419) _____ E-mail _____

Parents/Guardian name (please print) _____

School and Community Affiliations (Clubs, churches, sports, etc.) _____

Reason for Volunteering _____

I hereby apply for membership in the Junior Auxiliary Program. I agree to comply with the requirements and regulations of the service.

Date _____ Applicant Signature _____

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My daughter/son, _____, has my consent to serve as a volunteer at Galion Community Hospital. I further give my permission for grades to be checked quarterly so that if help is needed, time off can be given.

Date _____
Patent/Guardian Signature _____

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The above named has proven herself/himself as qualified to serve as a volunteer, and has maintained at least a "C: average in school work.

Date _____
School Principal or Guidance Counselor _____

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Date Interviewed _____ Date of Acceptance _____
Volunteer Services Coordinator _____