SPEAK Applicants,

Thank you for your interest in our summer Student Volunteer Program! We commend you for making a positive choice as to how to spend your summer.

Students Performing Exceptional Acts of Kindness (SPEAK) is an excellent opportunity for you to impact the lives of children through volunteering. Our program is designed to allow you to interact with patients through structured activities. As a SPEAK participant you will visit patients with the toy cart and book mobile. You will assist in play rooms and participate in structured play activities with patients.

We will select 20 participants from the applicant pool. When selecting our volunteers we are looking for someone who:
is happy to accept a task;
has a positive attitude;
is able to follow directions and be trusted;
has a desire to help patients and their families;
is fun, outgoing, and able to work well with others.

This application is your first impression with us. Please make sure your application is complete and on time. We will be unable to accept incomplete or late applications. Once we receive your completed application, we will notify you by e-mail to schedule your interview. We will primarily communicate through e-mail. Please regularly check the e-mail address you provide so that you do not miss important directions and deadlines. Below is a checklist for you to use to keep track of the application process.

	Activity	**Deadline**
	Application Due with references Email: donna.lewis@oumedicine.com Mail: 1200 Children's Avenue Box 71, attn: Donna Lewis Oklahoma City, OK 73104	4:00pm on March 28th, 2018 *if mailing must be postmarked before this date
	Schedule Interview	Between April 2nd-5th, 2018
	Interviews	April 9thand 10th, 2018
	Selected Participants Notified	April 13th, 2018
	Drug Screens Completed	April 20th, 2018
	Background Check Consent Forms Submitted	4:00pm on April 20th, 2018
	TB Skin Test	TBA
	TB Test Read	TBA
	Program Begins	Week of June 4th

The Children's Hospital VOLUNTEERS

All applications must be received or post marked by 4:00PM on Friday, 3/28. Incomplete applications will not be accepted.
Upon receiving your completed application, we will contact you with directions to schedule your interview (4/9 or 4/10). We will accept 20 participants.

The Children's Hospital VOLUNTEERS

Participants will be selected and notified by 4/13

NAME AND CONTACT INFORMATION			
LAST NAME	FIRST NAME		MIDDLE INITIAL
DATE OF BIRTH	AGE	GENDER	
HOME ADDRESS	CITY/STATE		ZIP
HOME PHONE	CELL PHONE	EMAIL	
NAME OF SCHOOL		CURRENT GRADE	
PARENT/GUARDIAN'S NAME		PHONE NUMBER	
PARENT/GUARDIAN'S NAME		PHONE NUMBER	

HOW DID YOU HEAR ABOUT THE TEEN VOLUNTEER PROGRAM?

☐ SCHOOL ☐ PARENT ☐ FRIEND
☐ OTHER (PLEASE SPECIFY) _____

ARE YOU REQUIRED TO VOLUNTEER?

☐ YES ☐ NO	IF "YES," PLEASE EXPLAIN:

Have you ever been convicted (found guilty) of a crime (including probation(s) before judgement), or are there any pending criminal charges against you awaiting a hearing in a court of law? ☐ YES ☐ NO

If you answered YES, please explain.

PREVIOUS VOLUNTEER EXPERIENCE		
NAME OF ORGANIZATION	START/END DATES	TOTAL HOURS SERVED
VOLUNTEER DUTIES		
NAME OF ORGANIZATION	START/END DATES	
VOLUNTEER DUTIES		
NAME OF ORGANIZATION	START/END DATES	TOTAL HOURS SERVED
VOLUNTEER DUTIES		

AVAILABILITY

The Summer Program will take place Monday-Friday from 9:00 AM-3:00 PM, beginning June 4 and ending August 3. No more than 2 absences will be allowed. Please indicate which day (Mon. -Fri.) you would prefer. We will not have SPEAK the week of 7/2-7/6.

PREFERRED DAY OF WEEK	WHAT SCHEDULING CONFLICTS DO YOU FORESEE? (VACATIONS, SPORTS, ETC).

WHAT TRANSPORTATION ARRANGEMENTS HAVE YOU MADE?

How could The Children's Hospital Volunteers benefit from having you as a volunteer?

What makes you different or sets you apart from others applying to this program?

Where do you see yourself in 3 to 5 years? What are your career interests?

Give an example of a time when you did something kind.

Give two examples that show you are a dependable person.

What would make you feel that you had a successful volunteer experience at The Children's Hospital? What would you like to get out of this program?

SUBMISSION GUIDELINES

Please submit the following items with your appication.
Incomplete applications will not be considered. **No Exceptions.**
** All applications are due by 4:00PM on Friday, March 28th **

□ Completed application form, including signed Statement of Understanding
□ Personal Reference Form. Must be from a teacher, coach, employment supervisor, or small group leader. References from family members will not be considered.
□ Signed Parental Consent Form
□ Immunization Records. The Children's Hospital requires that all volunteers provide proof of Varicella and MMR (Measles, Mumps, Rubella).

Volunteers will be required to take 2 TB tests with 2 follow up readings (4 visits total). Dates will be given upon acceptance into the program.

STATEMENT OF UNDERSTANDING

I acknowledge that all information I have submitted is true and has been submitted voluntarily. I understand that this information may be disclosed to any party with legal and proper interest. I release The Children's Hospital Volunteers and The Children's Hospital at OU Medical Center from any liability whatsoever for supplying such information.

I understand that attendance is expected and **no more than two absences will be allowed.** I also understand that I must be available to complete TB tests and training sessions prior to June 4th. Dates will be announced upon acceptance.

I understand that I must be at least 16 by June 4 to be eligible for the program.

I understand that the SPEAK Program at The Children's Hospital has a selection process and a limited group size, and I am not guaranteed placement.

I understand that, upon being selected, I will be required to provide additional pertinent information, including a background check and drug screening.

Applicant's Signature: _____ Date:_____
Parent/Guardian's Signature:_____ Date:_____

Dear Parent or Guardian:

In order for your child to apply to the SPEAK Summer Program at The Children's Hospital, we need your consent and involvement in helping your child have a productive experience. Please carefully read and sign this parental consent form if you would like us to continue our process of considering your child as a possible volunteer. If you have any questions or would like further information, please call Donna Lewis at 405-204-7122 or email donna.lewis@oumedicine.com.

Name of prospective volunteer:_____

If agreed upon, please initial next to each statement below.

I understand that my child wishes to be considered for a volunteer placement, and I hereby give permission for him/her to serve in that capacity if accepted.	
I understand that my child must be 16 before June 4.	
I understand that my child must be current on all required vaccinations prior to being accepted as a volunteer and agree to provide the appropriate documentation.	
Skin tests for Tubercluosis will be administered by The Children's Hospital free of charge. Dates will be announced upon acceptance.	
I understand that my child will be provided with the orientation and training necessary for the safe and responsible performance of duties assigned. He/she will be expected to meet all the requirements of the position, including regular attendance and adherence to the Children's Hospital Volunteers' policies, procedures, and dress code.	
I understand that my child will be provided emergency medical care if injured while he/she is on duty as a volunteer.	
If selected, I agree to make attendance a priority for my child and am aware of transportation arrangements made by my child. I understand that he/she may only miss two sessions.	
I authorize The Children's Hospital Volunteers to publish or release to the media any pictures of my child during his/her service for promotional use or recognition purposes only. * *This is not mandatory.*	

Parent/Guardian's Name (please print): _____

Signature:_____ Date:_____

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CONFIDENTIAL SCHOOL RECOMMENDATION

This form must be completed by a teacher or academic counselor and may NOT be given back to the student. It must be sent directly to The Children's Hospital Volunteers.

STUDENT'S INFORMATION

Student's Name: _____ Grade:_____

Name of School: _____

Parental Consent: *I authorize the release of information from my child's school records to the The Children's Hospital Volunteers and OU Medical Center.*

Parent/Guardian's Signature:_____ Date:_____

RECOMMENDATION FORM

Dear Counselor or Teacher:

A student applying for volunteer service must have a recommendation from a school representative no later than 3/28. Your evaluation and comments are appreciated. Please use the link below for a confidential online reference or mail this form directly to:

The Children's Hospital Volunteers
Attention: Donna Lewis
1800 Everett Drive
Box 71
Oklahoma City, OK 73104
OR: **https://www.surveymonkey.com/r/K2995QK**

	Excellent	Good	Average	Below Average
Attendance				
Courtesy				
Dependability				
Initiative				
Scholastic Record				
Participation				

Comments: _____

_____

_____

_____

_____

Printed Name: _____ Title:_____

Signature: _____ Date:_____