



Dear Prospective Volunteer:

Thank you for your recent inquiry regarding the Junior Volunteer Program at White Plains Hospital. Volunteers are an essential part of providing exceptional care to our community. We are looking for individuals who can make a minimum commitment of at least 70 hours per year.

**Administrative process/next steps to become a volunteer:**

- Apply for working papers at your school (for ages 14-15)
- Complete volunteer application and mail to: White Plains Hospital - Volunteer Services, 41 East Post Road, White Plains, NY 10601
- Upon review of application for potential assignment, match, and reference check— you will be called to schedule a personal interview

**Upon assignment confirmation:**

- Complete Orientation Paperwork
- Complete Health Clearance Forms- *including appointment with White Plains Hospital Occupational Health Office to obtain a health clearance, those volunteering during flu season are required to receive a flu vaccination*
- Follow-up appointment to issue Hospital ID, parking tag and confirmation of start date and assignment specific training

We look forward to meeting with you as you pursue a successful and rewarding volunteer career!

Sincerely,

Roseanne Braiotta  
Director, Volunteer Services  
(914) 681-1225



**WHITE PLAINS HOSPITAL JUNIOR VOLUNTEER APPLICATION**

(No questions on this application is asked for the purpose of limiting or excluding any applicant's consideration for volunteer placement based on race, color, religion, age, sex, marital status, sexual orientation or national origin. Confidentiality will be maintained.)

Full Name: \_\_\_\_\_ Gender: \_\_\_\_\_  
*Last First M.I.*

Address: \_\_\_\_\_  
*Street Address Apartment/Unit #*  
\_\_\_\_\_  
*City State ZIP Code*

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Working Papers #: \_\_\_\_\_  
(Junior Volunteers must be between 14 and 17 years old) Required for ages 14-15

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Year Graduating: \_\_\_\_\_

In Emergency Notify: \_\_\_\_\_  
\_\_\_\_\_  
Parent/Guardian (h) \_\_\_\_\_  
(w) \_\_\_\_\_  
(c) \_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Physician's Name ( ) \_\_\_\_\_  
Physician's Phone Number

\_\_\_\_\_  
Physician's Address City/State/Zip Code

Are you volunteering for school credit or an internship? No\_\_\_\_ Yes\_\_\_\_

Number of Hours: \_\_\_\_\_ Start Date: \_\_\_\_\_ Completion Deadline: \_\_\_\_\_

**AVAILABILITY**

We require a **70 hour minimum** commitment obtained within one year.

Number of times per week you are willing to volunteer \_\_\_\_\_

Check available times:

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Morning	_____	_____	_____	_____	_____	_____	_____
Afternoon	_____	_____	_____	_____	_____	_____	_____
Evening	_____	_____	_____	_____	_____	_____	_____

## INTERESTS

I would prefer:  Direct Patient Contact     Administrative/Clerical     Whatever Is Most Needed

Please select the areas that interest you:

Nursing Units     Front Desk     Patient Transport     Administrative/Clerical  
 Gift Shop     Patient Library     Other: \_\_\_\_\_

Are you able to perform the essential job duties of the position for which you are applying? YES  NO

Briefly, please describe why you are interested in volunteering at White Plains Hospital:

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## EXPERIENCE

Other volunteer experience/community involvement:

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Work experience (general):

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Skills/Hobbies/Language skills that you are willing to share:

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List any experience with office equipment, computers, and/or software:

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## REFERENCES

*Please list two professional references. They cannot be family members or friends.*

Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

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Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

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## DISCLAIMER and SIGNATURE

*I have answered each question fully and correctly. I understand that any deliberate misstatement could disqualify me or cause termination of my volunteer position at White Plains Hospital. I authorize White Plains Hospital to check my medical background and reference checks. I have read and clearly understand the above statements.*

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(required)

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(required)