Dear Student:

Thank you for your interest in Hawaii Pacific Health's Volunteer Programs at Kapi'olani Medical Center for Women & Children, Pali Momi Medical Center, and Straub Medical Center. Our volunteer high school programs at Kapi'olani and Straub in Honolulu are held year round and the program at Pali Momi (a six week program) is only available during the summer from June through July.

- The minimum age to participate is 16 years old.
- You are required to volunteer 4 hours per week. This can be done by doing two 2-hour shifts, twice a week; or one 4-hour shift, once a week – (equivalent to 48 hours in a 3-month period).
- You may continue in our high school program as long as you are able to make the time and service commitment to volunteer on a consistent basis.
- To receive credit for volunteering for school/club or to receive a letter of recommendation, you must comply with the program's commitment requirements and leave the program in good standing.

If you are interested in joining our volunteer team and can commit to volunteering on a consistent basis, please complete and send in your application. All applications are processed through our Volunteer Services office located at:

Kapi’olani Medical Center  
Attn: Volunteer Services  
1319 Punahou Street  
Honolulu, Hawaii 96826

When we receive your application and determine that there are openings, you will be sent a packet of forms and health clearance requirements which must be completed within 30 days of you receiving them. If there are no openings at the time we review your application, you will be notified. Thank you for your interest in becoming an important part of our dedicated health care team.

Sincerely,

Lisa Chung  
Director, Volunteer Services
# HIGH SCHOOL VOLUNTEER APPLICATION

(Select the Medical Center you are applying for)

- **KAPI'OLANI**
  1319 Punahou Street, Honolulu

- **PALI MOMI** (summer only)
  98-1079 Moanalua Road, Aiea

- **STRAUB**
  888 S. King Street, Honolulu

## GENERAL INFORMATION

Name: __________________________ Birthday: ____________

Last First M.I. Month/Day

Address: __________________________ City: ____________ Zip: ____________

Phone (Home): ___________________ (Cell): ____________ Email Address: __________________________

Emergency Contact Person: __________________________

Relation: __________________________ Phone: (H) __________________ (Cell): ____________

Physician Name: __________________________ Phone: ____________

High School: __________________________ Grade: ____________ Age: ____________

(must be at least 16 years old)

## AVAILABILITY

Days/times you are available to volunteer? Please check below:

(Minimum 4 hours per week; one 4-hour shift or two 2-hour shifts):

<table>
<thead>
<tr>
<th>Time</th>
<th>Mon</th>
<th>Tue</th>
<th>Wed</th>
<th>Thu</th>
<th>Fri</th>
</tr>
</thead>
<tbody>
<tr>
<td>8/8:30a.m. - Noon</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>12:30p.m. - 4/4:30p.m.</td>
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</tbody>
</table>

Will you be attending summer school? ☐ Yes ☐ No

## TYPES OF JOBS YOU ENJOY

- ☐ Patient Escort
- ☐ Patient Greeter/Visitor Assistant/Hospitality
- ☐ Book Cart
- ☐ Running Errands
- ☐ Reading to Patients
- ☐ Arts & Crafts with Patients (Kapiʻolani Medical Center for Women & Children only)

## OTHER INFORMATION

Work experience (paid or volunteer):

Career interests:

Special interests, hobbies, skills:

After HPH receives your application and determines there are openings, you will be sent health requirements and other documents. **Documents must be completed within 30 days from the date you receive them or your application will be removed, unless we hear from you.** If there are no openings, you will be notified. I agree to abide by the policies and regulations of Hawaiʻi Pacific Health and its High School Volunteer Program.

Signature: __________________________ Date: ____________

## DO NOT WRITE BELOW - FOR VOLUNTEER OFFICE USE ONLY:

Date App Rec’d: ____________ Date Pkt Sent: ____________ Parent Permission: ____________ Jr. Eval: ____________ ER Treatment: ____________ Health Consent: ____________

HEALTH RECORDS: TB: (1) ____________ (2) ____________ or X-Ray ____________ MMR ____________ HepB ____________ Chicken Pox ____________ Flu ____________

Orientation: ____________ Start: ____________ Day: ____________ Time: ____________ Assign: ____________

Start: ____________ Day: ____________ Time: ____________ Assign: ____________

N.O.L.: ____________

Revised 9.2.16