SAINT ANTHONY MEDICAL CENTER

5666 E. State Street, Rockford, IL 61108
Phone (815)395-5064 Fax (815) 227-2165

PERSONAL REFERENCE FORM

Junior Volunteer Program

To be completed by a teacher, counselor, or job supervisor.

Name of Applicant:: ____________________

Name of Reference: ____________________

Relationship to Applicant: ____________________

How long have you known the applicant? ____________________

The person listed above has applied for the Junior volunteer Program at OSF Saint Anthony Medical Center. Please complete the form below and return it to our office (at the address above) at your earliest convenience. This applicant will not be considered for the program until all forms are completed. The information requested will be kept in strict confidence. If you have any questions, please contact the Volunteer Services Manager at 815-395-5065. Thank you for your assistance.

Please comment on the applicant's:

Attitude: ____________________

Ability to get along with others: ____________________

Dependability: ____________________

Ability and willingness to follow directions: ____________________

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Honesty and integrity: ____________________

Do you recommend this applicant for a junior volunteer position? Yes No

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Additional comments: (Please use back of sheet if necessary) ____________________

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