PERSONAL REFERENCE FORM 1
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/HealthCare 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 coordinator at (815)395-5064. 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: _______________________________________________________

Honesty and integrity: ________________________________________________________________________

Do you recommend this applicant for a Junior Volunteer Position: Yes ______   No ______

Additional comments: ________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________
PERSONAL REFERENCE FORM 2
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/HealthCare 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 coordinator at (815)395-5064. 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: _____________________________________

____________________________________________________________________________

Honesty and integrity: _________________________________________________________

Do you recommend this applicant for a Junior Volunteer Position: Yes ______ No ______

____________________________________________________________________________

Additional comments: _________________________________________________________

____________________________________________________________________________

____________________________________________________________________________
CAREFULLY READ THIS SECTION PRIOR TO PROVIDING SIGNATURES BELOW

PARENT OR GUARDIAN:
I hereby give my approval as parent or guardian of _______________________________________
to be a Volunteer at OSF Healthcare if a volunteer position is offered.

I understand that OSF HealthCare will not assume any responsibility for the above named minor to
his/her signing in for duty or following his/her signing off of volunteer duty.

Parent or Guardian: ___________________________ Date: _________________

JUNIOR VOLUNTEER:
I hereby affirm that the information on this application is true and complete. I understand that any
false or misleading representation or omissions made on the application or during the hiring process
may disqualify me from further consideration for a volunteer position and may result in discharge
even if discovered at a later time.

I understand that OSF HealthCare is not obligated to provide placement, nor am I obligated to accept
a position if one is offered. Opportunities for volunteers are provided without regard to religion,
creed, race, national origin, age, or sex.

Volunteer Signature: ___________________________ Date: _________________

Send your completed application to:
OSF/HealthCare Saint Anthony Medical Center
Volunteer Services
5666 E. State St.
Rockford, IL.  61108
Fax: (815)227-2165
Phone: (815)395-5064