Student/Volunteer Application

To be completed by student or volunteer on or prior to first day. Please review other documentation provided by hosting therapist prior to first day in clinic. After a review of your application, you and hosting therapist will complete necessary facility forms.

Date:
Name:
Phone Number:
Address:
City:
State:
Zip:
Emergency Contact: Relationship:
Emergency Contact Number:
School Affiliation:
Major:
Timeline: *Dates you are requesting to complete volunteer or observation hours?* ***(For Volunteers Only)***
Availability: *Days & Times you are available.* ***(For Volunteers Only)***

List current and previous volunteer work ***(For Volunteers Only):***

_____

_____

_____

List any requirements that you have of Pediatric Rehab staff and dates associated with each document: (Ex. student evaluations, recommendations, goals, etc.)

_____

_____

_____

_____

Have you had any personal experience(s) involving? If so please explain.
_____ Pediatric Therapy _____Children ____ Disabilities

_____
_____
_____

How did you learn of Pediatric Rehab?
_____
_____

_____ _____
Applicant Signature Date

Office Use:

_____ HIPAA Form

_____ Orientation

_____ Dress Code and Personal Conduct

_____ Universal Precautions and Infection Control

_____ Policies and Procedures (Fire, Disaster, and Evacuation)

_____Equipment Safety Policies and Procedures

_____ _____
Therapist Signature Date