



**Mercy Hospital**  
Volunteer Services  
615 South New Ballas  
St. Louis, MO 63141  
(314) 251-6180

## Teens Learning in the Community Mercy TLC Volunteer Program

**\*\*Only complete and legible applications will be considered (write clearly and large enough to read). This includes date of birth AND social security number as well. Yes, it is needed, include it. You will not be considered without it. \*\***

### **Personal Information**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

Birth date: \_\_\_\_\_

Social Security Number (**must include to obtain co-worker ID#**): \_\_\_\_\_

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

School: \_\_\_\_\_

Grade / Year: \_\_\_\_\_ Year you plan to graduate: \_\_\_\_\_

### **Emergency Contact**

In case of an emergency, notify:

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

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

Work Phone: \_\_\_\_\_ Who is your family physician? \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

### **Volunteer Information**

How did you hear about the TLC Volunteer Program? \_\_\_\_\_

\_\_\_\_\_

If referred to the program, name of individual who referred you: \_\_\_\_\_

Do you need to report these hours to anyone? \_\_\_\_\_ If so, who & why? \_\_\_\_\_

Why do you want to volunteer? \_\_\_\_\_

\_\_\_\_\_

Have you had any previous volunteer experience? If so, please explain. \_\_\_\_\_

\_\_\_\_\_

What, if any, experience have you had with a hospitalized person? \_\_\_\_\_

\_\_\_\_\_

Are you currently employed? \_\_\_\_\_ If so, where do you work and what is your job? \_\_\_\_\_

\_\_\_\_\_

### **Volunteer Statement**

I wish to contribute my service to Mercy Hospital St. Louis in the Teen Learning in the Community Volunteer Program. I understand that there is no payment for my services. I am aware that my volunteer experience will not always involve direct patient contact. I agree to abide by the rules, regulations, and policies of Mercy Hospital and I will work under the direction of Volunteer Services Staff and other hospital staff. I understand that I must maintain confidentiality regarding patient and family information. If I do not abide by the rules, regulations, and policies, or break confidentiality, it may result in my termination from the TLC Volunteer Program. The following dates are mandatory and will be in attendance on June 10<sup>th</sup>, 12<sup>th</sup>, and 17<sup>th</sup>. There will be no volunteering the week of July 4<sup>th</sup> to observe the Independence Day holiday. Two absences will be permitted outside of the required dates and July 4<sup>th</sup> holiday week. The last day of the program will be Thursday July 31<sup>st</sup>.

Volunteer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I have read and understand the above information and hereby give consent for my son / daughter to participate in the TLC Volunteer Program at Mercy Hospital St. Louis.

Parent / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please complete the application, questionnaire and have a letter of recommendation submitted by the

**Deadline February 14<sup>th</sup>, 2025 to:**

Mercy Hospital St. Louis  
Volunteer & Guest Services  
615 South New Ballas  
St. Louis, MO 63141

The application can be emailed to [Loredana.Leone@mercy.net](mailto:Loredana.Leone@mercy.net)