

2025 Rising Star Youth Volunteer Program Application

Contact Information

Legal Full Name	
Previous Names or Alias	
Street Address	
City, State and ZIP Code	
Phone Number	Primary Phone: <input type="checkbox"/> Cell <input type="checkbox"/> Home Secondary Phone: <input type="checkbox"/> Cell <input type="checkbox"/> Home
Email Address	
Date of Birth (Must be a currently enrolled high school sophomore, junior or senior and at least 14 years old)	
Gender	<input type="checkbox"/> Female <input type="checkbox"/> Male
Parent/Guardian Name	
Parent/Guardian Phone Number	
Parent/Guardian Email Address	

Emergency Contact

Name:	Relationship:	Phone: Email:
Name:	Relationship:	Phone: Email:





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Education Information

Name of School:	Year in School: I am currently a <input type="checkbox"/> Senior <input type="checkbox"/> Junior <input type="checkbox"/> Sophomore
Career Desired:	Expected Graduation Year:
GPA:	

Volunteer Preferences & Interests

<input type="checkbox"/> 1 st Session June 9-20, 2025 <input type="checkbox"/> 2 nd Session July 7-18, 2025 <input type="checkbox"/> Could attend either session (June or July)
Why are you interested in volunteering?

Please list any extra-curricular activities, skills or interests that may help us place you in a volunteer position:
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Volunteer Area Preference

Please select your top 5 volunteer areas from the list below. Rank as 1, 2, 3, 4 and 5, with 1 being your highest interest.					
<input type="checkbox"/>	Direct Inpatient Care	<input type="checkbox"/>	Pediatric Physical Therapy	<input type="checkbox"/>	Lifefit and Cardiac Rehab
<input type="checkbox"/>	Birthing Center	<input type="checkbox"/>	Express Care	<input type="checkbox"/>	Inpatient Rehab Unit
<input type="checkbox"/>	Physician Office	<input type="checkbox"/>	Operating Room	<input type="checkbox"/>	Physical Therapy
<input type="checkbox"/>	Comm. Health-Phys. Fit Testing	<input type="checkbox"/>	Respiratory Therapy	<input type="checkbox"/>	Infusion Center, Radiation Oncology

Referral

How did you hear about the Rising Star Youth Volunteer Program at Beaufort Memorial Hospital?
Are you related to with anyone who is a volunteer or employee at Beaufort Memorial Hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name & relationship: Department:





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Personal History

Do you have any mental or physical restrictions, which might prohibit you from volunteer job duties?

Yes No

If so, please advise:

Have you ever been convicted of a crime, other than a traffic violation or misdemeanor, in the last 7 years?

Yes No

If so, please explain:



Beaufort Memorial

Committed to **Community**
Committed to *You*



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Volunteer Applicant Certification and Release

I hereby certify that all information given by me on this application is true and correct to the best of my knowledge and I grant Beaufort Memorial Hospital permission to verify all information. I understand that any misleading or false statement or omission of pertinent information, whether on this application or not, may be considered as sufficient cause for rejection of this application.

I consent to a background or other investigative service check prior to my volunteer service and I understand my service is contingent upon successful completion of this requirement.

I understand that the use of illegal drugs is prohibited during my service to Beaufort Memorial Hospital.

I understand that if accepted as a volunteer, I will comply with the below core values:

- **Safety**.....Keep patients, visitors, co-workers and ourselves safe. Zero harm is the ultimate goal.
- **Innovation**.....Creatively apply new ideas, streamline processes and build excellence into everything we do to create value for our patients.
- **Compassion**.....Act with genuine empathy and concern for the well-being of others.

I will comply with the Beaufort Memorial rules, regulations, and policies of the hospital and the unit or department where I am assigned. Either the hospital or the volunteer may terminate the service relationship at any time with or without notice or cause.

Agreement and Signature

My name below is acknowledgement that the above has been communicated to me and that I have had the opportunity to ask questions.

Youth Volunteer Acknowledgement: Name

Date

If you have any questions please contact Kathy Bingham at Kathleen.bingham@bmhsc.org or 843-522-5835



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