Mercy Medical Center
Teen TAG Volunteer
School/Community Teen Reference Form

_________________________ (print name) is applying to become a Mercy Ambassador Teen Volunteer at Mercy Medical Center. Please complete the following information about the applicant, which will help us in our evaluation for the appropriate placement assisting our patients, families, and staff.

Mercy Ambassador Teen Volunteers must be willing to help others, have a high degree of maturity, and be self-motivated.

ALL INFORMATION PROVIDED ON THIS FORM IS CONFIDENTIAL.

How long have you known the applicant? ______________________________

In what capacity have you known the applicant? ____________________________

Please describe the character of the applicant.

___________________________________________________________________

In your opinion, what strengths would the applicant bring to our volunteer program?

___________________________________________________________________

___________________________________________________________________

Would you recommend this applicant as a teen volunteer in a hospital and why?

___________________________________________________________________

Please share any other information that you feel would be helpful to us in considering this applicant.

___________________________________________________________________

___________________________________________________________________

___________________________________________________________________

Thank you for your time.

Date: ______________ Phone: __________________

Printed Name: __________________________ Signature: __________________________

Please return form to:
Volunteer Services Office
Mercy Medical Center
1320 Mercy Drive NW
Canton, Ohio 44708
Fax: (330) 580-4794
Phone: (330) 489-1106