Sibley Memorial Hospital
Volunteer Service Department
5255 Loughboro Road NW
Washington, D.C. 20016
P: (202) 537-4485
F: (202) 370-6585

SIBLEY MEMORIAL HOSPITAL
JOHNS HOPKINS MEDICINE

Confidential School Recommendation

To be completed by the Volunteer Applicant and Parent/Guardian

_____ _____

Applicant Name Date

Parent/Guardian Consent

I authorize the release of information from my child's school records to the Department of Volunteer Services at Sibley Memorial Hospital.

_____ _____

Parent/Guardian Signature Date

To be completed by the Applicant's Teacher or School Counselor

Please fill out this form on behalf of the student named above and return it to the student in a signed and sealed envelope. This form will be used to evaluate the student's eligibility for enrollment as a volunteer at Sibley Memorial Hospital.

_____ _____

Name Date

_____ _____

School Title (counselor, teacher, etc.)

Use the table below to provide information about the Applicant:

	Excellent	Good	Average	Below Average
Attendance	☐	☐	☐	☐
Courtesy	☐	☐	☐	☐
Dependability	☐	☐	☐	☐
Initiative	☐	☐	☐	☐
Scholastic Record	☐	☐	☐	☐
Willingness	☐	☐	☐	☐

Use this space to include anything else about the Applicant that may help in determining their qualifications. Feel free to attach further comments.

_____

_____

I certify that the answers above are complete and accurate: _____

Signature