Pinckneyville Community Hospital
Leading the way to a healthier tomorrow.

CONFIDENTIAL SCHOOL RECOMMENDATION

Student Name: _____

Parental Consent: I authorize a representative from my son/daughter's school to complete this form and send to the Department of Volunteer Services at Pinckneyville Community Hospital.

Parental Signature: _____ Date: _____

Dear Counselor or Teacher:

A student applying for volunteer service must have a recommendation from a school representative. Your evaluation and comments are appreciated. The information you provide may be reviewed by Marketing Director and Social Services Coordinator. You may give the student the evaluation in a sealed envelope with your signature across the flap or you may mail it to the address listed below. Mailed recommendation forms must be postmarked by the application deadline, April 30, 2018.

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

Comments: _____

_____

_____

_____

Name (Print): _____ School: _____

Title: _____

Signature: _____ Date: _____

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