PROVIDENCE HOSPITAL

February 20, 2020

Dear Applicant:

Thank you for your interest in our teenage volunteer program. We are blessed to have many interested teenagers in our program; however, we MUST limit our number of teenage volunteers to 80 to keep our Teenagers busy. Returning teenagers are given the opportunity to sign up first by February 21st then **applications for new volunteers will be accepted beginning Monday, February 24**. The selection will be based on THE DATE THE APPLICATION IS RECEIVED. Once we have received 80 applications we will no longer be able to guarantee you a position in the program.

If you are considering investing in our summer program you MUST be **sincere and committed** to your service as a teenage volunteer. Due to the time invested in orienting new volunteers, each teenage volunteer must work a minimum of 20 hours service this summer. Our teenage volunteers begin serving, June 1 through July 9, 2020. **You will need to be here one day each of these six weeks. We will only have Teenage Volunteers on Monday – Thursday.** Make-up days can be requested.

A hospital is a highly regulated environment and **all teenage volunteers must attend orientation and training** so they can protect our patients' rights to safety and privacy. Because a great deal of time is invested in your training, we ask that you please fulfill your commitment. We ask you to consider your other commitments this summer, such as sports/band camps, family vacations, etc. If you do not volunteer at least 20 hours, we will not issue a certificate to be used for organizations such as National Honor Society, scholarship applications, etc. and you **will not** be eligible to participate in the program the next year.

Prospective teenage volunteers must complete the following steps before being accepted in our program:

1. Complete Application – Each prospective teen must complete an application, which includes parental permission to volunteer at the hospital
2. Sign Confidentiality Statement (both teenager and parent)
3. Have two teachers or counselors complete the attached reference forms
4. Send a copy of your most recent report card
5. Complete and sign Medical Release Liability Form
6. Make fitting appointment for proper scrub size (Details upon acceptance.)
7. Must have completed the 8th grade and be between the ages of 14 – 18
8. Grade point average must be a C or above

You are required to attend one of two parent/teenager orientation and training sessions on May 11 or May 14 at 6:00 pm in the DePaul Center here on the Providence campus.

You are only required to attend one orientation.

Our teenage volunteers wear red scrubs with the TAV logo and **clean tennis shoes**. This Dress Code is mandatory. Once you have been selected as a teenage volunteer, we will give you details on being fitted for your scrubs. The cost of these scrubs will be around $35 and can be purchased at Scrubs by Zoghby's. For both girls and boys, hair styles must be conservative, no perfume or aftershave may be worn, and visible tattoos are not allowed.

We are excited about the opportunity to work with you this summer and assist you in giving back to your community through volunteer service. I think you will find this to be a very rewarding experience.

Remember once we have 80 applications we cannot guarantee you a position in the program.

APPLICATIONS FOR NEW VOLUNTEERS WILL NOT BE ACCEPTED UNTIL MONDAY, FEBRUARY 24.

If you have any questions, please call the Volunteer Office at 266-1338.

Sincerely,

Karen Dixon

Karen D. Dixon
Program Manager, Volunteer Services

(Application is on the next page, please print legibly)

PROVIDENCE HOSPITAL - ASCENSION
TEENAGE VOLUNTEER APPLICATION

NAME:_____
LAST FIRST MIDDLE I. PREFERRED NAME

ADDRESS:_____

CITY & ZIP:_____PHONE:_____

CELL PHONE:_____E-MAIL:_____

DATE OF BIRTH: _____

SCHOOL PRESENTLY ATTENDING:_____
What GRADE will you be in starting in the FALL:_____

Why do you want to volunteer in a healthcare setting?

NAME OF PARENT OR GUARDIAN:

BUSINESS PHONE: _CELL PHONE:

As a teenage volunteer I understand I am required to:

1. Have completed the eighth grade and between the ages of 14 and 18.
2. Maintain a C grade point average. **Attach copy of most recent report card to this application.**
3. Follow the hospital rules and regulations as specified on the attached liability, confidentiality statement and as instructed in hospital orientation.
4. Contact the Teenage Volunteer Coordinator immediately regarding any absences from duty. Failure to do so may result in termination from the volunteer program.

Signature of Teenager _____Date_____

Signature of Parent/Guardian_____Date_____

FOR OFFICE USE ONLY

Date Received_____ Date of Teenager/Parent Orientation: _____

Reference Statement___Confidentiality Statement__Medical Release/Liability Statement_____

Report Card_____Grade Average_____

ACKNOWLEDGMENT STATEMENT
CONFIDENTIALITY OF PATIENT HEALTH INFORMATION
DO NOT SIGN THIS STATEMENT UNTIL YOU HAVE READ IT THOROUGHLY!

As a volunteer of Providence Hospital (PH), I understand that I must hold medical and other patient information in confidence. I understand "confidential information" of any information which I have seen, heard, learned of or contributed to during the course of my volunteering with PH, regardless of whether the information is in written or other tangible form.

I agree not to discuss, reveal, copy or in any other manner disclose the contents of any medical record or information concerning a patient who has or is receiving health care services, unless I am authorized to do so through an appropriate and properly executed "request for release of medical information" where it has been determined and ordered by the appropriate authority that the information is to be released, or the necessary authorization and consent has been obtained from the patient. I will always have the "request for release of medical information" form approved by a staff member in the Medical Records Department.

I understand that medical records are confidential: that the information contained in a medical record is protected by both Federal and Alabama State law, and the reading, discussing, or otherwise using the information within the record for purposes other than legitimated health care concerns is grounds for immediate dismissal and possible adverse action.

I understand that I have the responsibility for safeguarding the confidentiality of patient information and the contents of any medical record maintained on a patient, regardless of whether the patient is currently receiving medical services from PH. I further understand that it is the policy of PH to maintain the confidentiality of patient information both during and after a patient's receipt of medical services from PH, and I agree to maintain this confidentiality both in and out of the hospital.

I understand that disclosure of medical information to persons other than health care professionals may be an invasion of a patient's privacy rights. I further understand that patient medical information is of a personal and private nature and that I must demonstrate respect and concern for the patient's rights to privacy and, knowing this, agree to take all responsible precautions to prevent the unauthorized disclosure of any personal or confidential medical information to include the proper destruction of materials. Examples of prohibited disclosures include:

*looking a friend up in the computer to see how he/she is doing,

*checking the computer or medical record to see if a friend's grandchild has been born,

*using patient information for personal purposes such as a mailing list.

By signing this statement, I acknowledge that I have read and understand the contents of this statement and the meaning of confidentiality. I further acknowledge that I understand the hospital's policy concerning the confidentiality of patient medical information, that disclosure of patient medical information to persons other than health care professionals for the purpose of treatment is a breach of the patient's privacy rights, and that failure to abide by the hospital's policy regarding confidentiality, privacy and security will result in disciplinary action and/or termination of my association with Providence Hospital.

Teenage Volunteer Signature Date

Parent's Signature Date

PROVIDENCE HOSPITAL
MEDICAL RELEASE/ PARENT LIABILITY FORM

Teenage Volunteers Name _____

Home Address: _____

Home Phone: _____

Parent(s) Guardian _____

Work Phone _____

Alternative Contact(s)

Phone

Health Care Insurance Company

Policy # _____ Group#_____

LIABILITY POLICY

If you are injured while performing volunteer services, it shall be the policy of Providence Hospital to provide immediate and necessary first-aid treatment including x-rays and diagnostic tests at the expense of the hospital. Should the injury necessitate further treatment, it is the responsibility of the individual volunteer to provide his/her own health insurance.

PARENT/GUARDIAN – Please check the appropriate statements

_____ I give permission for immediate emergency medical treatment. Notify me and/or any persons listed above as soon as possible.

_____ I <u>DO NOT</u> give permission for emergency medical treatment until I have been contacted.

List ALL allergies, medication reactions or other conditions that may need to be known in an

emergency situation:

PARENT/GUARDIAN SIGNATURE DATE

PROVIDENCE HOSPITAL
TEENAGE VOLUNTEER PROGRAM
RECOMMENDATION

As a teenage volunteer, you are required to obtain a personal recommendation from a school counselor, teacher, pastor or adult non-family member who has worked with you in a supervisory capacity. Teenagers accepted into the volunteer program must demonstrate responsibility, commitment and dedication to Providence Hospital's mission to serve, to care and to heal the sick. Comments should address your qualities in those areas. Your application will not be accepted until this recommendation has been received. Please use this form to obtain your recommendation and return it with your application to Volunteer Services.

Date: Teenager's Name: _____

Reference Name: Phone Number:

Address:

What is your relationship with this applicant?

How long have you known this applicant?

Would you recommend this applicant for the teenage volunteer program at Providence Hospital?

How would you rate the applicant's overall competence? (Check one.)

Outstanding _____ Good _____ Average _____ Fair _____ Poor _____

Please state briefly what you believe to be the applicant's greatest strengths and weaknesses (if any):
Strengths

Weaknesses

May a representative of Providence Hospital's Volunteer Services Department contact you if further information is required? Yes: No:

SIGNATURE of Person Making Recommendation Date

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