

PROVIDENCE HOSPITAL AUXILIARY  
P. O. Box 850429  
Mobile, AL 36685

February 28, 2010

Dear Applicant:

Thank you for your interest in our teenage volunteer program. We are blessed to have many interested teenagers in our program. Because of this, we can only accept those teenagers who are committed to their volunteer duties and can invest at least 20 hours of service this summer. Our teenage volunteers serve from June 1 until July 16<sup>th</sup>. Because of the many rules and training requirements, teenage volunteers cannot be involved in direct patient care. Their activities are limited to clerical duties, assisting in surgery waiting rooms, delivery of supplies and assisting the hospital staff.

A hospital is a highly regulated environment and **teenage volunteers must attend orientation and training** so they can protect our patient's right to safety and privacy. Because a great deal of time is invested in your training, we ask that you fulfill your commitment. We ask you to consider your other commitments this summer, such as band camp, family vacations, etc. If you do not volunteer at least 20 hours, we will not issue a certificate nor verify that you volunteered, i.e, National Honor Society, scholarship applications, etc.

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 a teacher or counselor complete the attached reference form.
4. Send a copy of your most recent report card.
5. Complete and sign Medical Release Liability Form.
6. **Stop by Volunteers office to be measured for proper scrub size.**

The requested forms must be returned to Volunteer Services before April 8, 2009. Teenagers who are accepted will be notified by April 19, 2009, and asked to attend one of two parent/teenager orientation and training on Sunday, May 16<sup>th</sup> at 2:00 p.m. or Monday, May 17<sup>th</sup> at 6:30 p.m. in the DePaul Center.

This year, our teenage volunteers will be wearing red scrubs with the TAV logo and white tennis shoes. The Dress Code is mandatory; therefore, it is important that everyone come by the Volunteer office no later than April 8<sup>th</sup> to try on our sample scrubs to determine their appropriate size. Our office is open Monday through Friday, 7:30 a.m. until 4:00 p.m.. The cost of these scrubs will be just under \$30 and can be paid at orientation in May. 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.

If you have any questions, please call the Volunteer Office at 251-633-1335.

Sincerely,

Jamey Greer  
Director, Volunteer Services

(Application is on the next page)



**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.

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Volunteer Signature

Date

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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 DO NOT 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

PROVIDENCE HOSPITAL  
TEENAGE VOLUNTEER PROGRAM  
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How long have you known this applicant? \_\_\_\_\_

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\_\_\_\_\_

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Outstanding \_\_\_\_\_ Good \_\_\_\_\_ Average \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_

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

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\_\_\_\_\_

Weaknesses \_\_\_\_\_

\_\_\_\_\_

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

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SIGNATURE of Person Making Recommendation

\_\_\_\_\_  
Date