February 15, 2011

Dear Applicant:

Thank you for your interest in our teenage volunteer program. We are blessed to have many interested teenagers in our program; however, this year we are reducing the number of teenage volunteers from 100 to 50. As a result we need to determine if the applicants are sincere. Due to the time invested in orienting new volunteers, we ask for a minimum of 20 hours service this summer. Our teenage volunteers serve beginning June 6 through July 15th. **<u>You will need to be here one day each of these six weeks.</u>**

A hospital is a highly regulated environment and **<u>teenage volunteers must attend orientation and training</u>** 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 1, 2011. Teenagers who are accepted will be notified by April 15th, and are required to attend one of two parent/teenager orientation and training on Sunday, May 15th at 2:00 p.m. or Monday, May 16th at 6:30 p.m. in the DePaul Center.

Our teenage volunteers wear 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 May 13th 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)

PROVIDENCE HOSPITAL
TEENAGE VOLUNTEER APPLICATION

NAME:____
LAST FIRST MIDDLE I. PREFERRED NAME

ADDRESS:____

CITY & ZIP:_______________________________________PHONE:__________________

CELL PHONE:_______________________________E-MAIL:________________________

DATE OF BIRTH:______ __________________ ______

SCHOOL PRESENTLY ATTENDING:___________ ________GRADE IN FALL:_________

Why do you want to volunteer in a healthcare setting?_________________________________

____

NAME OF PARENT OR GUARDIAN:____

BUSINESS PHONE:____________________CELL PHONE:______________________

UNIFORM SIZE: ___________

As a teenage volunteer I understand I am required to:

1. Have completed the eighth grade and be 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.

____

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 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

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