ORTHOPEDIC & SPINE INSTITUTE
at St. Mary's Medical Center

Teen Volunteer Application (For applicants 16-17 years old)

Thank you for interest in serving as a volunteer at the Paley Orthopedic & Spine Institute. We are currently recruiting volunteers who can meet our minimum commitment of four hours per week for at least a 3 month period. If you are a student or seasonal resident seeking a volunteer opportunity for less than three months, please explain your availability in detail on the enclosed application. Please give this serious thought before you commit; our patients and staff count on volunteers.

I am interested in:

❑ 4 hr weekly commitment to the Paley Orthopedic & Spine Institute ❑ Events for the Paley Orthopedic & Spine Institute ❑ Events for the unLIMBited Foundation

INFORMATION

First Name: _____ Last Name: _____ Date: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell phone: _____

Email Address: _____

Date of birth (mm/dd/yyyy): _____ (Copy of birth certificate required)

Have you ever worked at Paley Orthopedic & Spine Institute?

❑ YES ❑ NO

Do you have any physical limitations, medical limitations, or mental disorders that would impair your ability to perform as a volunteer at the Paley Orthopedic & Spine Institute without any supplemental assistance?

❑ YES ❑ NO

If YES, please explain: _____

_____

Have you ever been convicted of a crime? (an affirmative response will not automatically disqualify you from being considered)

❑ YES ❑ NO

If YES, please explain: _____

_____

EMERGENCY CONTACT INFORMATION (please list someone we can contact in case of an emergency):

Emergency Contact Name: _____

Relationship: _____

Email: _____

Emergency Contact Phone Number: _____

Family Physician: _____

Family Physician Phone Number: _____

NAME OF FRIENDS OR RELATIVES EMPLOYED OR VOLUNTEERING AT THE PALEY ORTHOPEDIC & SPINE INSTITUTE:

Full Name: _____

Relationship: _____

Department: _____

Full Name: _____

Relationship: _____

Department: _____

PERSONAL REFERENCES (PLEASE LIST THREE PERSONAL REFERENCES (Employers, Volunteer Supervisor, Teacher, etc. -No Relatives)

Full Name: _____

Relationship: _____

Email: _____

Phone: _____

Full Name: _____

Relationship: _____

Email: _____

Phone: _____

Full Name: _____

Relationship: _____

Email: _____

Phone: _____

Full Name: _____

Relationship: _____

Email: _____

Phone: _____

SHORT RESPONSE:

What is your previous volunteer experience? For each experience, please include the following information:

Volunteer program name and description _____

_____

Your role (for example: volunteer team captain, board member, etc) _____

_____

Responsibilities/ activities performed _____

_____

Dates as an active volunteer _____

_____

Reason for leaving _____

_____

Do you speak a second language? ❑ YES ❑ NO If YES, which language and are you conversational or fluent? _____

Do you play any musical instruments? ❑ YES ❑ NO If YES, please elaborate on your experience. Would you be comfortable to play in patient rooms or in front of an audience at the medical center? _____

What special skills, interest or strengths would you offer as a volunteer? Please note if any of the following categories are applicable and elaborate.

❑ Art, if so which mediums? _____

❑ Crochet or sewing _____

❑ Computer literate, if so which programs? _____

❑ Website design _____

❑ Tutoring, if so which subjects? _____

❑ Photography _____

❑ Other skills _____

Have you ever volunteered for the Paley Orthopedic & Spine Institute or unLIMBited Foundation before?
❑ YES ❑ NO If YES, , please note which organization and dates of service.

Please explain in detail why you would like to volunteer at the Paley Orthopedic & Spine Institute or unLIMBited Foundation _____

_____

_____

How did you learn about the volunteer opportunities at the Paley Orthopedic & Spine Institute? _____

_____

To help us schedule you, please indicate the days and hours that you are available to volunteer. Please note that at this time, there are limited weekend and evening volunteer shifts available. Are you a seasonal resident?

❑ YES ❑ NO If YES, , which months are you available?

Volunteer interest in (please provide top two choices):

1. _____

2. _____

Is there anything else you would like to address or share about yourself? _____

_____

EDUCATION AND WORK EXPERIENCE:

High School _____

- Grade as of June 2019 _____
- GPA (Proof is required) _____
- Extracurricular Activities _____
- Sports _____
- Dual Enrollment/AP/IB classes _____
- Awards or Recognitions Received _____

Work Experience (Part time job, babysitting, internships, etc.) _____

Licenses or Certificates earned (CPR, lifeguard, etc.) _____

PLEASE CHECK THE ANSWERS THAT APPLY TO YOU:

❑ I treat volunteer commitments with the same respect I do as work, school, or business commitments

❑ I am looking for hands on experience to practice the skills I learned at school

❑ I have time available and would like to give back

❑ I am looking for hands on experience to decide on a college major

❑ I am comfortable working around patients

❑ I hope my volunteer position will lead directly to employment at the Paley Orthopedic & Spine Institute.

❑ I have carefully considered my schedule and I know I can make the commitment to volunteer.

APPLICANT'S STATEMENT

I hereby affirm that the information provided on this application is true and complete to the best of my knowledge and agree to have any of the statements verified by the Paley Orthopedic & Spine Institute. I understand that providing any false or misleading information or any omissions may disqualify me from further consideration as a volunteer and may result in my immediate termination even if discovered at a later date. I authorize all references provided in this application, as well as all other individuals to provide all information they have about me. Furthermore, I agree to cooperate in such investigation and release from liability or responsibility, the Paley Orthopedic & Spine Institute and all persons and entities acting on its behalf, and all persons and entities requesting or supplying such information.

Signature: _____ Date: _____

Read and complete Part A, Part B, and Part C. Part A requires a parent or guardian's signature in order to participate in the Teen Volunteer Program. Part B requires a parent or guardian's signature should an emergency arise while on duty. Part C requires a parent or guardian's authorization to give PPD test.

PART A: PARENTAL CONSENT TO VOLUNTEER

My son/daughter has my permission to volunteer the Paley Orthopedic & Spine Institute.

I understand that he/she is making a commitment to volunteer service and will support this is commitment, which includes reporting for duty at the scheduled times every week, except in the event of illness.

I understand that, in the event of illness, it is my son's/daughter's responsibility to notify the Volunteer Office and the department where he/she is assigned of his/her absence.

I have read and agree with the above Statement of Consent and Responsibility.

Name of Volunteer: _____

Parent or Guardian Signature: _____ Date: _____

PART B: EMERGENCY ROOM TREATMENT AND RELEASE FORM

It is legally required to obtain parental consent prior to treating a volunteer in the Emergency room should an illness or injury occur while he/she is on volunteer duty. Please sign below to give permission to give any necessary first aid or emergency treatment should an illness or injury occur while your son/daughter is on duty.

Also, please state to whom the child may be released from the Emergency Room in the event that the parent/ guardian is not available.

Name of Volunteer: _____

Parent or Guardian Signature: _____ Date: _____

Name of alternate to whom teen may be released: _____

Name of alternate to whom teen may be released: _____

PART C: CONSENT FOR TUBERCULIN SKIN TEST AND REQUIRED IMMUNIZATIONS

I give the Employee Health Department of the Paley Orthopedic & Spine Institute authorization to give a PPD test (Tuberculin skin test) and required immunizations.

Name of Child: _____

Parent or Guardian Signature: _____ Date: _____

VOLUNTEER EXPECTATIONS

I. I shall hold as absolutely confidential all information that I may obtain directly or indirectly concerning patients, doctors or personnel, and not see to obtain confidential information from any patient.

II. I will donate my services to the Paley Orthopedic & Spine Institute without expectation of compensation or future employment and give my service for humanitarian and charitable purposes.

III. I shall not sell or attempt to sell goods or services, request contributions or solicit persons to sign or distribute any petitions on hospital property.

IV. I shall submit to initial and annual health screening requirements, which may include tuberculosis screening, flu shot, lab tests and/or immunizations that may be necessary as part of my service.

V. I will be punctual and conscientious, conduct myself with dignity, courtesy and consideration of others, and will maintain a professional appearance and provide quality service.

VI. I will resolve any problems related to my volunteer service with my supervisor and/or with the Volunteer Services Coordinator.

VII. I will not accept tips or gifts from patients and visitors.

VIII. I understand that my assigned supervisor and Volunteer Services depend on my reliability. If unable to be present, I will call my assigned supervisor two (2) hours before a scheduled shift.

IX. I agree that if I miss four (4) shifts with unexcused absences, I shall be removed from the volunteer program.

X. I understand Volunteer Services does not place individuals in volunteer positions to be trained for paid positions.

XI. I understand Volunteer Services does not provide a "shadowing" program or provide internships.

XII. I understand that if I engage in inappropriate behavior; i.e., horseplay, using foul language, gossiping, using cell phones during service times, and other discourteous behavior, will be cause for immediate removal from the volunteer program.

XIII. I will uphold the philosophy, standards and values of the Paley Orthopedic & Spine Institute at all times in my interactions with patients, visitors, and other hospital staff and volunteers.

XIV. I understand that the Volunteer Services Department may release me as a volunteer of the Paley Orthopedic & Spine Institute at any time.

XV. I understand that the Paley Orthopedic & Spine Institute assumes no responsibility for any contact, visits or services provided by me that are beyond the scope of responsibilities defined for my specific assignment.

I have read and understand the Volunteer Expectations as stated above and agree to follow them in all aspects of my service to the Paley Orthopedic & Spine Institute.

Signature of Teen Volunteer: _____

Print Name: _____ Date: _____

Signature of Parent or Guardian: _____

Print Name: _____ Date: _____

CONFIDENTIALITY POLICY ACKNOWLEDGMENT

I understand and agree that as a volunteer of the Paley Orthopedic & Spine Institute, I have a moral, legal, and ethical responsibility to maintain confidentiality of all information regarding patients, business operations, medical staff and employees. Specifically, information pertaining to a patient's condition, records, or personal affairs and information related to personnel, payroll, purchasing, costs, charges, and patient accounts is considered confidential.

I fully understand the confidentiality requirements placed upon me as a volunteer of the Paley Orthopedic & Spine Institute and I affirm that all are reasonable and understood. I understand that my services may be terminated if I, in any manner breach any policies and procedures regarding confidentiality.

PERMISSION TO COMMUNICATE VIA TEXT

All communication conducted electronically shall be for the purpose of official business of the Paley Orthopedic & Spine Institute Volunteer Services Department. Your signature below gives permission to communicate via text at the number provided.

Further, your signature acknowledges any charges incurred in the receipt from or replies to these texts are not the responsibility of the Paley Orthopedic & Spine Institute.

Phone number to text: _____

Service Provider (i.e.: AT&T, Verizon, T-Mobile, etc.) _____

Signature of Teen Volunteer: _____ Print Name: _____ Date: _____

Signature of Parent or Guardian: _____ Print Name: _____ Date: _____

MEDIA POLICY

All media requests should be referred to the business development office immediately.

Only authorized personnel from the administrative staff or business development staff are permitted to speak with or deal with members of the media. No members of the media may be on our St. Mary's campus without business development or administrative approval.

Volunteer Signature _____ Date: _____

Parent/Guardian Signature _____ Date: _____

AUTHORIZATION AND CONSENT TO PHOTOGRAPH AND PUBLISH INFORMATION, STATEMENTS AND IMAGES

The undersigned hereby authorizes and consents to permit the Paley Orthopedic & Spine Institute and its affiliates, and its and their respective successors and assigns (collectively, "Hospital") to use and publish, or permit other persons to use and publish, in any public manner Hospital deems reasonably appropriate, his or her name, voice, photograph, likeness, quotes, stories and/or any other information, statements or images (collectively, "Personal Materials") obtained in connection with the undersigned's employment by, or other performance of services for, Hospital: (1) for any commercial or non-commercial purposes, including but not limited to, for marketing, advertising, fundraising, development, public relations, media relations, charitable, educational and scientific purposes; and

(2) in the form of print, audio, visual and social media, including but not limited to, articles, blogs, websites, brochures, pamphlets, newsletters, fliers, posters, advertisements, newspapers, film, live or taped television transmission, videotape, radio broadcast, and internet publication, it being understood and agreed that such authorization is subject only to the following limitations, if any: _____.

The term "photograph" as used in this agreement shall mean motion picture, still photography or visual recording of any kind and in any format such as slides, negatives, prints, videotape, video disc, and any other means of recording and reproducing images, including composite or modified representations.
Except as specifically stated above, the undersigned hereby waives any and all rights he or she may have with respect to any Personal Materials and all images or materials created from them. Without limiting the generality of the foregoing, the undersigned specifically waives (i) any rights he or she may have to be paid or otherwise compensated for the use of such Personal Materials, other images and materials, (ii) any rights he or she may have to control the manner of use of such Personal Materials, other images and materials, and (iii) any rights he or she may have to inspect or approve the finished product incorporating or based on, in whole or in part, the Personal Materials, other images and materials, including but not limited to photographs and printed matter that may be used as described above. Furthermore, the undersigned and his or her successors and assigns hereby release and hold Hospital and its officers, directors, agents and employees harmless from and against any claim for injury or compensation resulting from the activities authorized by this authorization and consent.

How long will this authorization be in effect?

This authorization expires on the earlier of the following: The date that the Paley Orthopedic & Spine Institute ceases to run the testimonial/campaign or 10 years from the date of authorization.

Print: _____ Signature: _____

Signature of Parent or Legal Guardian (for minors): _____ Date: _____

Phone Number: _____ Email: _____

LETTER OF RECOMMENDATION FORM

As a Teen Volunteer at the Paley Orthopedic & Spine Institute, we require one letter of recommendation. This letter may be written by anyone outside of your immediate family. You may ask a teacher, counselor, coach or supervisor (no friends or family members) to recommend you for this position. Please ask them to tell us about your strengths and what would make you a great volunteer at the Paley Orthopedic & Spine Institute. They may fill out this form or type a recommendation letter to attach.

_____

_____

_____

_____

_____

_____

_____

_____

Signature of Referral: _____ Date: _____

Print Name: _____

Name of Teen Volunteer: _____

Relationship to Teen Volunteer: _____

VOLUNTEER PROGRAM REQUIREMENTS

- Be 16-17 years of age
- Preferred CPR training within the last 2 years
- Commit to at least three months of volunteer service
- Undergo successful criminal background check
- Complete and submit the Volunteer Application form
- Submit a copy of your driver's license (required for background check)
- Attend an interview with one of the departmental staff
- Provide the following proof of health an immunization records
    - ~ Negative Tuberculin (TB) Tests-
    - ~ Measles, Mumps, Rubella (MMR)
    - ~ Chicken Pox (Varicella)
    - ~ TDAP- Tetanus, Diptheria and Pertussis or Whooping Cough (last 10 years)
    - ~ Flu Vaccine- Required during flu season