Teen – 14 ½ to 17 yrs. old

When completing this application, please Print Info. in black ink.

Arrowhead Regional Medical Center
Department of Volunteer Management
400 N. Pepper Avenue
Colton, California 92324
(909) 580-6340

# TEEN VOLUNTEER APPLICATION

_____ _____
Last Name, First Name, Middle Initial Date of Birth

_____
Home Address ~ Number, Street, Apt. # City State Zip Code

_____
Mailing Address ~ Number, Street, P. O. Box City State Zip Code

(____)_____ (____)_____ (_____)_____
Home Telephone Number Cell Telephone Number Work Telephone Number / Ext.

If you are fluent in any other Non-English language, please specify :

Language: _____ ☐ Speak ☐ Read ☐ Write

Language: _____ ☐ Speak ☐ Read ☐ Write

## EDUCATION

Name of school you attend: _____ Current grade level: _____

School Affiliations: _____

## WORK EXPERIENCE

(Beginning with your current or most recent position. Please include any volunteer work.)

| | |
|---|---|
| From: (Mo./Yr.) _____<br>To: (Mo./Yr.) _____ | Title: _____ Company: _____ Paid ☐ Volunteer ☐<br>Brief description of your responsibilities: _____<br>_____ |
| From: (Mo./Yr.) _____<br>To: (Mo./Yr.) _____ | Title: _____ Company: _____ Paid ☐ Volunteer ☐<br>Brief description of your responsibilities: _____<br>_____ |
| From: (Mo./Yr.) _____<br>To: (Mo./Yr.) _____ | Title: _____ Company: _____ Paid ☐ Volunteer ☐<br>Brief description of your responsibilities: _____<br>_____ |

List your interests/hobbies: _____

What are your career goals?_____

_____

Indicate the type of volunteer work you would prefer:_____

(Due to Liability Issue's – We do NOT participate in any type of hands-on patient care)

How did you hear about our program? _____

Have you ever been a volunteer at this hospital (A.R.M.C.) before? Yes ☐ No ☐

If yes, please indicate:

Date(s):_____ Position:_____ Department: _____

I MUST attach and submit with this application (3) three letters of recommendation from adults who are non-relatives and who have known me for at least one (1) year.

Emergency Notification: Person to notify in case of an emergency:

| _____ | _____ | (____)_____ |
|---|---|---|
| Name | Relationship | Telephone Number |

I understand that if accepted as a volunteer at A.R.M.C. I must: comply with hospital policies, rules and regulations; maintain active dependable participation in the program; maintain satisfactory attitude, appearance and work performance levels; strictly observe hospital ethics and rules of confidentiality; and treat all patients, visitors and staff with dignity, kindness, understanding, and respect.

My services are donated to A.R.M.C. without contemplation of compensation or future employment and give with humanitarian, religious or charitable reasons.

I understand that failure to provide complete, accurate, truthful information on this application may be grounds for immediate dismissal from the program.

I agree to accept termination from the program at any time and for any reason, if in the judgment of the department director, my continued service as a volunteer is contrary to the best interests of the hospital.

| _____ | _____ |
|---|---|
| Signature of Applicant | Date |

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# CONFIDENTIALITY STATEMENT

I understand and agree that in the performance of my duties as a volunteer of Arrowhead Regional Medical Center, I must hold medical information in confidence.

Further, I understand that intentional or involuntary violation of patient confidentiality,
including information contained in the patient medical records, may result in stringent disciplinary action against me, including immediate dismissal from the program.

_____ _____

Volunteer's Name (Please Print) Volunteer's Signature

**I authorize Arrowhead Regional Medical Center Volunteer Management to contact me if I am ill or hospitalized.**

Yes_____ No_____

_____ _____

Volunteer's Name (Please Print) Volunteer's Signature

_____

Date

Arrowhead Regional Medical Center
Department of Volunteer Management

# Emergency Information

_____ (_____)_____
Last Name, First Name, Middle Initial Home Telephone Number

Health information that might be important in the event you require emergency treatment:

| Medications You Take | Drug Sensitivities | Allergies |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Special health concerns: _____

_____

_____

_____ (_____)_____
Personal Physician Telephone Number

_____
Name of Clinic or Hospital

Person(s) to notify in an emergency:

| Name | Relationship | Telephone Numbers | |
|---|---|---|---|
| | | Home | Cell |
| | | ( ) | ( ) |
| | | ( ) | ( ) |
| | | ( ) | ( ) |

_____ _____
Signature of Volunteer Date

**Parental/Student Agreement**
**Arrowhead Regional Medical Center**
**Teen Volunteer Program**

I agree to and will abide by the following policies set forth by Arrowhead Regional Medical Center Hospital's Teen Volunteer Program:

1. I will commit to 100 hours per year of volunteer work at Arrowhead Regional Medical Center.

2. I understand that if I miss more than 2 assignments, I will be placed under a probationary period subject to termination.

3. When I am unable to make my shift I will call at least 24 hours in advance to notify the department of my absence.

4. I agree to abide by the Policies and Procedures of the Volunteer Department of Arrowhead Regional Medical Center including appropriate dress, hairstyle, attitude and willingness to cooperate.

5. I understand that there are no breaks or meal periods allowed during the work shift if it is 4 hours or less. Please make every effort to eat before signing in.

6. I understand that homework is allowed only in selected areas at selected times. We recommend you bring in homework to work on when no errands are to be run. However, if an order comes in you must immediately run the errand.

I have read and agree to the above requirements of the program.

_____ _____
Volunteer Name Date

I have read and will support the above requirements of the program.

_____ _____
Parent/Guardian Date

**ARROWHEAD REGIONAL MEDICAL CENTER**
**Department of Volunteer Management**
**Parental/Guardian Consent Form**

I hereby give permission for my child _____ to serve in a volunteer capacity at Arrowhead Regional Medical Center, if accepted by the agency. I understand my child will be expected to meet all the requirements of the position, including regular attendance and adherence to applicable Medical Center policies and procedures. I understand they will not receive monetary compensation for the services contributed. All volunteer positions serve at the pleasure of the County Medical Center and may be terminated at any time without cause.

Should my child become ill or be injured while volunteering, I authorize the Medical Center, its employees, and physicians to provide medical treatment as indicated, if I cannot be notified. I will be financially responsible for costs incurred for all treatment.

I understand that my child must obtain health clearance before beginning their volunteer assignment. If I am unable to provide documentation to meet health clearance requirements, I authorize Arrowhead Regional Medical Center to perform the following procedures, if indicated, on my child at no cost to me:

- Screening test(s) for Tuberculosis (Mantoux/Chest X-ray).
- Blood test to determine immunity to Measles, Mumps, Rubella and/or Varicella.
- Vaccination for Measles Mumps, Rubella and/or Varicella if my child is not immune.
- Vaccination with Tdap (Tetanus, Diphtheria, Pertussis)
- Annual flu vaccination (October-March)
- If applicable, I also authorize the Medical Center, its physicians and employees to administer a series of vaccinations for Hepatitis B and perform post-vaccination serology testing.
- Other screening and/or immunization deemed necessary as the situation arises may be undertaken on the advice of the Infection Control Chairman and Hospital Administration.

Child's Name: _____

Health Insurance Information: Company name _____

Group # _____

Subscriber # _____

Name of person carrying insurance: _____

I have had an opportunity to ask questions regarding all aspects of my child's participation in the volunteer program at Arrowhead Regional Medical Center and have had any questions answered to my satisfaction.

_____ _____
Parent/Guardian's Name (Printed) Signature of Parent/Legal Guardian

_____ _____
Relationship to Volunteer Date Signed

_____ _____
Witness' Name (Printed) Signature of Witness/Date