Letter to Applicant – FALL VolunTEEN

Applications accepted September 1st – October 1st

Thank you for your interest in this year's FALL VolunTeen Program. The FALL Volunteen Program is for students ages 15-18 (applicant must be 15 by August 1 and have completed 9th grade). Due to the large number of students interested in the program, **it is essential that you pay close attention to the information given and that you are aware of the deadline by which this information must be returned to Volunteer Services.** In order to ensure the quality of the Program, there are limited spaces available. **Late or incomplete packets will not be considered.**

Mandatory Health Screens and/or Fall FLU SHOTS and Orientation will be required prior to the start date. Health Screens/ Fall Flu Shots and Orientation is mandated by The Joint Commission, a government agency that accredits hospitals. **There will be no makeup dates given.** Health Screens/Flu Shots and Orientation dates will be provided upon approval of the application. If there are unavoidable conflicts with the date set for orientation, our policy will not permit you to participate this year.

Our Fall VolunTEEN program runs during the month of November each year. Our policy will not permit you to participate if you have other obligations that will conflict with volunteer work commitments, requirements and dates required to complete the fall volunteen program. (**There will be no exceptions.)**

Each Fall VolunTEEN is required to volunteer at least 4 hours (1 shift) per week as is determined to be both productive and convenient for you and the unit manager – the shifts can run in any 4 hour increments from 2-8 p.m. depending on when the teen school schedule. Each student must volunteer a **minimum of 20 hours** during the Fall VolunTEEN program in order to complete the program.

The Fall VolunTEEN Program's primary aim is to teach the value of community service and to provide experiences that foster inner growth, maturity and strengthen a service-oriented mind. It also provides an opportunity to acquire some of the required volunteer service hours needed to meet high school class requirements at the beginning of the school year the hours are needed.

Volunteens are not allowed to administer any type of clinical care. Assignments are in a hospital or related setting and provide a wonderful opportunity for students to learn and explore healthcare careers. Participants must comply with all Vidant Roanoke-Chowan Hospital policies and procedures at all times.

Volunteen Applications must be received in the Volunteer Office no later than **5:00 P.M**. on **October 1st or the next weekday).** Packets must be filled out completely and correctly (ATTACH MOST RECENT SHOT RECORD if you did NOT participate as a volunTEEN within the last 12 months) for further consideration for the Program. If packets are incomplete when they are turned in, they will not be considered eligible to participate in the program.

All applicants will be informed of their status via email by October 10th. Teens that are selected to participate will continue in the registration process.

Thank you for your interest in the FALL Volunteen Program! Please let me know if you have questions!

Sincerely,
Robin Bland
Volunteer Coordinator
Vidant Roanoke-Chowan Hospital
252-209-3290 - rbland@vidanthealth.com

Checklist for VolunTeen Registration

Due Date: no later than 5:00 P.M. on October 1st (or the next weekday)

Following instructions closely is an important step to becoming a Volunteen and will show Volunteer Services that you are responsible. This list is to ensure that you have no confusion about what you need to do to become a Volunteen and to make certain that all forms are completed and turned in on time.

Check each of the following off as you complete them. **DO NOT wait until the last minute to complete these forms. Deadline extensions are not permitted.**

_____ Locate the application packet posted on the Volunteer Services link on the VidantHealth.com web site and read through the forms with a parent or guardian. Discuss summer plans and whether you will be able to attend orientation (usually held during the 4th week in October – the actual date will be provided in your acceptance letter/email) and if you can commit to volunteering one 4-hour shift per week during the fall program period (usually held each weekday during the month of November).
We stress this to you because if there are already unavoidable conflicts with these dates, hospital policy will not permit you to participate this FALL.

_____ Fill out the application neatly and completely. It is preferred that you type in the form if using the Microsoft Word Document format but if you do not have access to Word, please complete the application in Adobe pdf format neatly by hand. Make sure that you complete everything that has a **bold border** around it. **Incomplete applications will not be considered.**

_____ Complete packets must contain the following forms:

- Application
- Immunization Records (for first time applicants or if teen hasn't volunteered in over a year)
- **All applicants will be required to take the flu shot during the FALL health screen process and/or provide proof that you've received it, unless you have a medical or religious reason why you cannot take it.**

The Letter to Applicant and the Checklist should not accompany your application. They are meant for your purposes only.

_____ Mail to or drop off your completed application in the Volunteer Services Office:
Vidant Roanoke-Chowan Hospital
Volunteer Services
500 South Academy Street
Ahoskie, NC 27910

Application packets must be received no later than 5:00 P.M. on October 1st (or the next weekday) to be considered on time to proceed with the rest of the registration process.

Volunteen Application

Contact Information	
Name (First & Last)	
Street Address	
City, State Zip Code	
Home Phone	
Cell Phone	
E-Mail Address	
Social Security Number	
Date of Birth	/ /
Age	
Gender	
Current School	
Current Grade	
Are you in Health Sciences Academy?	☐ Yes ☐ No
Are you related to anyone that works at Vidant Roanoke-Chowan? If yes, give name and relationship.	☐ Yes ☐ No
Do you have any physical limitations or are you under a doctor's care for any illness?	☐ Yes ☐ No
Polo shirt size (adult)	S ☐ M ☐ L ☐ XL ☐ XXL ☐
Parent/Legal Guardian Information	
Name	
Relationship to you	
Work Phone	
Cell Phone	
E-Mail Address	
Parent/Legal Guardian Information	
Name	
Relationship to you	
Work Phone	
Cell Phone	
E-Mail Address	

Availability

Tell us which days you are most available to volunteer. Rank in order of preference from 1-3 (1 being your top choice).

FALL program hours:

___Monday	**(3:30 – 7:30 pm)**	**Other _____**
___Tuesday	**(3:30 – 7:30 pm)**	**Other _____**
___Wednesday	**(3:30 – 7:30 pm)**	**Other _____**
___Thursday	**(3:30 – 7:30 pm)**	**Other _____**
___Friday	**(3:30 – 7:30 pm)**	**Other _____**

What areas interest you?

___Transport (radiology)
___Nursing (inpatient units)
___Other (lobby greeters, Vidant Wellness Center)

_____

Activities

Please list any activities that you are involved in throughout the school year & summer, including: employment, volunteer work, hobbies, clubs, sports, or community organizations. Also, please list any academic honors you have received.

ESSAY QUESTIONS: Please answer the following questions briefly.

How do you feel you can make a difference at Vidant Roanoke-Chowan Hospital? Please list any special skills you feel could benefit our patients, staff and visitors.

What distinguishes you from your peers? Why should you be chosen to be a volunteen here at Vidant Roanoke-Chowan Hospital?

What do you hope to gain from participating in Vidant Roanoke-Chowan Hospital's Fall Volunteen Program?

Applicant Agreement and Signature

By submitting this application, I affirm that the facts set forth in it are true and complete. I understand that if I am accepted as a volunteen, any false statements, omissions, or other misrepresentations made by me on this application may result in my immediate dismissal.

Teen Name (printed)	
Signature	
Parent/Guardian Name	
Parent/Guardian Signature	
Date	/ /

Parental Consent

I,_____, have read all registration information and consent to allow my child,_____, to apply and to be considered for the Volunteen Program.

Parent Signature:_____ Date: / /

Acknowledge and Release: Substance Prevention Policy

I have been informed and acknowledge that Vidant Health and its subsidiary corporate entities have a Substance Abuse Prevention Policy which includes a Zero Tolerance Provision. I understand that applicants for positions with these corporations may receive pre-employment drug screening as part of the hiring process and that hiring decisions are contingent upon the results.

I specifically consent and agree to provide body fluid samples (blood and/or urine) for drug and/or alcohol screening in accordance with the policy as part of the application process.

I understand that if I am not accepted because of a positive drug screen, I will not be reconsidered for volunteer service at Vidant Health or any of its subsidiary corporate entities until I can document twelve (12) continuous months of treatment for drug abuse.

I understand and specifically consent and agree that any positive drug screening results will be furnished to the appropriate Volunteer Department and to my professional licensing board, if appropriate, I further understand that once accepted, subsequent positive screens or refusal to provide samples when requested will make me subject to disciplinary action up to and including termination.

I hereby make application for service with the Vidant Health Volunteer Services Department. I agree to abide by the volunteer ethics as presented in orientation to keep all patient information strictly confidential, and to comply with all rules and regulations.

Teen Name (printed)	
Signature	
Parent/Guardian Name	
Parent/Guardian Signature	
Date	/ /

Consent Waiver and Release

I hereby give permission to Vidant Health, and its subsidiaries and affiliated entities, including, but not limited to Vidant Medical Center; Vidant Health Foundation, Inc. d/b/a Vidant Medical Center Foundation, Inc. d/b/a Vidant Health Foundation, Inc.; HealthAccess, Inc.; SurgiCenter of Eastern Carolina, LLC d/b/a Vidant SurgiCenter; Vidant Health Physicians, LLC d/b/a Vidant Medical Group; East Carolina Health d/b/a Vidant Community Hospitals; East Carolina Health-Beaufort, Inc. d/b/a Vidant Beaufort Hospital; East Carolina Health-Bertie, Inc. d/b/a Vidant Bertie Hospital; East Carolina Health-Chowan, Inc. d/b/a Vidant Chowan Hospital; East Carolina Health-Heritage Inc. Vidant Edgecombe Hospital; East Carolina Health d/b/a Vidant Roanoke-Chowan Hospital; Duplin General Hospital, Inc. d/b/a Vidant Duplin Hospital; The Outer Banks Hospital, Inc.; and collectively "Vidant Health entities," to record, reproduce, publish, print, film, photograph, video, prepare, use or exhibit in any form whatsoever, including but not limited to electronically or digitally, by name, picture, image, portrait, likeness, voice, or any and all of them for the use noted below and without by prior examination of the finished product.

Any picture, portrait, photograph, photo transparency, audiovisual illustration, computer file, electronic image or other likeness constitutes the property of the Vidant Health entities and may be used without prior examination of the product.

I hereby waive my rights (or my child's rights) to privacy in connection with the consent given above and I hereby voluntarily waive, release discharge and agree to defend, indemnify and hold harmless Vidant Health entities, each of their successors, assigns, affiliates and subsidiaries; each of their directors, officers, trustees, agents and employees from any liability for any and all claims or causes of action I, my heirs or assigns might now or hereafter and further agree that this consent will not be made the basis of a future claim of any kind.

By affixing the signature below, I _____(print name) hereby certify that I have read and understand this CONSENT WAIVER AND RELEASE.

NOTE TO THE PARENTS AND TEEN APPLICANTS:

Applicants are chosen based on:

- Application – complete responses to all questions and providing all the requested information needed to process the application.
- Completing Health Screens to be cleared by our Occupational Health Nurse
- Previous Volunteer Experience
- Interest/Exposure in Health Care field

All applications have to be received in this office on/before **October 1st (current calendar year).**

If you have any questions, please contact us Monday through Friday, 8:00 a.m. – 5:00 p.m.

The Volunteer Office phone number is (252) 209-3248 or email me at rbland@vidanthealth.com

Teen Name (printed)	
Signature	
Parent/Guardian Name	
Parent/Guardian Signature	
Date	/ /

Disclosure/Authorization Statement

By this document, Vidant Health (VH) and its subsidiary corporate entities disclose to you that a consumer report may be obtained for employment purposes as part of the pre-employment background investigation and at any time during your employment.

This shall authorize the procurement of a consumer report by VH and its subsidiary corporate entities as part of the pre-employment background investigation. If hired, this authorization shall remain on file and shall serve as an ongoing authorization for the appropriate corporate entity by which I am employed to procure consumer reports at any time during my employment period.

In connection with this request, I authorize all corporations, companies, former employers, supervisors, credit agencies, educational institutions, law enforcement agencies, city, state, county, and federal courts, motor vehicle bureaus, military services and persons to release information they may have about me to the corporate entity of Vidant Health with which this form has been filed or an agent acting on its behalf and release all parties involved from any liability and responsibility for doing so.

This authorization, in original or copy form, shall be valid for this and any future reports or updates that may be requested.

I understand that I have the right upon written request within a reasonable period of time, to request additional disclosure as to the nature and scope of the investigation.

I authorize the National Personnel Records Center, St. Louis, MO or other custodian of my military records to release to the corporate entity of VH to which I am applying or its agent acting on its behalf, information, or photocopies of my military personnel and related medical records or only the following information/records:

Teen Name (printed)	
Teen Signature	
Social Security Number	
Drivers License Number	
State	
Date of Birth	/ /
Date	/ /

Volunteen Contract

A. Personal Appearance

1. The uniform consists of khaki (tan) pants or long skirt, a white shirt, and closed toe walking shoes. Your uniform must be worn at all times. Please do not wear hats, capris, shorts, baggy pants, cologne, nose jewelry, open toed shoes or sandals. All clothing items are to be clean, pressed and worn neatly.

2. Extreme styles/hair color and tints, i.e. fire engine red, blue, orange, pink, green, purple, multiple colors that are not naturally occurring, are not allowed.

3. Name badges are to be worn at all times while working and should always be visible.

4. Nails are to be clean and well trimmed. Clear or light color polish is permissible for females. Long fingernails are not appropriate.

5. Simple, conservative jewelry is allowable. Jewelry and wallet chains that dangle can present a safety hazard and are not allowed. **Facial piercing, tongue piercing, etc. can not be worn while volunteering.**

6. **YOU WILL BE REPRESENTING OUT HOSPITAL** - - Any Volunteen who comes to volunteer and is not dressed appropriately will not be allowed to volunteer until proper clothing is brought to the hospital or the Volunteen will be sent home.
If it occurs a second time, the Volunteen will be suspended from the program.

B. Behavior

1. Volunteens are expected to be in their work area or on an errand for their assigned department while signed- in.

2. Meal breaks should be taken before or after your shift. A $5 meal ticket is provided when you volunteer for at least a 4 hour shift.

3. No gum, no perfumes, no smoking, no profanity; no exceptions.

4. No personal calls, or cell phone usage including texting, are to be made while on duty.

5. Friends are not to visit Volunteens at the hospital. No personal patient visits are allowed while on duty.

6. Adults are to be addressed as Mr., Mrs., Ms. or Doctor.

C. Personal Responsibilities

1. Volunteens who are unable to work on an assigned day due to sickness are responsible for contacting the volunteer office at 209-3290.

2. Volunteens must sign-in and sign-out each day worked.

3. Volunteens are not to leave the hospital campus during their scheduled shift. Leaving may result in immediate dismissal from the program.

D. Rules Regarding Misconduct

1. Any rule stated in this contract or in the hospital conduct and discipline policy that is disobeyed can cause dismissal from the Volunteen Program. Our rules are for the good of the Volunteens, the program, and the hospital. It is imperative that the hospitals standards of excellence are always followed. Always conduct yourself as a representative of this hospital.

Teen Name (printed)	
Teen Signature	
Parent Name	
Parent Signature	
Date	/ /

VIDANT HEALTH™

Occupational Health

Confidential Record	
Name (First & Last)	
Social Security Number	
Date of Birth	/ /
Age	
Street Address	
City, State Zip Code	
Personal Physician's Name	
Physician's Address	
Physician's Phone number	- -
Name of Emergency Contact	
Emergency Contact Phone Number	- -
Allergies (Food-Medication-Latex, etc.)	

ACKNOWLEDGEMENT OF INSTRUCTION REGARDING ACCIDENTAL INJURY
If you sustain an injury while on duty at Vidant Health, please go to VMC Occupational Health.

ACKNOWLEDGMENT OF INSTRUCTION REGARDING BLOOD EXPOSURES
All **blood exposures** are to be immediately reported to the Manager/Supervisor/Charge Person and an Employee Event Form is to be **taken** to Vidant Roanoke-Chowan Occupational Health Department and given to the Occupational Health Nurse. If Occupational Health is closed, the Manager/Supervisor/Charge Person will contact the Patient Care Coordinator **immediately**. The Patient Care Coordinator will review the source patient's chart, and order a blood exposure panel (including a rapid HIV Test) and complete a risk assessment. If necessary, she will contact the source patient's attending physician and obtain orders for testing. She will direct the employee to the Emergency Department **only if post exposure chemoprophylaxis is indicated.** Otherwise, the employee will place the Employee Event form in the box outside the door of Occupational Health **and** contact the Occupational Health Nurse in person or by phone **as soon as the department re-opens**. Employees may also call the Blood Exposure Hotline (847-8500) for specific instructions at the time a blood exposure occurs. As a contracted employee, please follow
the algorithm for non-VH employees and blood exposures.

I have read the above information, and have had an opportunity to ask questions which have been answered. I understand that it is my responsibility to complete an Employee Event form at any time I have a job-related injury or exposure to any communicable disease.

Signature	
Date	/ /

Vidant Employee Clinic _____ Date _____

VIDANT HEALTH™

Occupational Health

VIDANT ROANOKE-CHOWAN H0SPITAL
AUTHORIZATION FOR TREATMENT OF MINORS

Hospital Infection Control policy requires documentation of immunization for measles, mumps, rubella, and tetanus/diphtheria, Tdap, Varicella (chicken pox) vaccine, Influenza vaccination as well as tuberculin skin testing. If adequate documentation is not provided, immunizations and/or lab testing will be required for your child.

Drug screening may be a part of the pre-employment process. It may also be done during employment if there is "reasonable cause".

I, the undersigned parent/guardian of _____, a minor, authorize Vidant Roanoke-Chowan Hospital Occupational Health Department, through its nurses to perform required medical screening/drug screening/immunizations; to comply with hospital policy for employees/volunteers of Vidant Roanoke-Chowan Hospital as outlined above.

Should my child need to be treated for minor illnesses and/or work related while employed/volunteering at Vidant Roanoke-Chowan, I give permission for treatment to be administered by the physician or nurses of Vidant Roanoke-Chowan Hospital Occupational Health Department or the Vidant Emergency Department.

_____
Parent or Legal Guardian

_____
Witness Signature

_____
Minor

_____
Witness Name (Please Print)

_____
Minor's Social Security Number

_____
Date

CONFIDENTIALITY STATEMENT:

Vidant Roanoke-Chowan Hospital

Mr. / Ms. / Miss / Mrs. NAME _____ DATE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE (HOME) _____ (WORK) _____ (CELL) _____

DATE OF BIRTH _____ EMAIL _____

CONFIDENTIALITY STATEMENT
Vidant Health has a legal and ethical responsibility to safeguard the privacy of all patients and protect the confidentiality of their health information. In the course of my assignment at Vidant Health, I may come into possession of confidential patient information, even though I may not be directly involved in providing patient services. I understand that such information must be maintained in the strictest confidence.

• As a condition of my assignment, I hereby agree that I will not at any time during or after my assignment disclose any patient information. When patient information will be discussed with the health care practitioners in the course of my assignment, I will use discretion to assure that such conversations will not be held in a public place or with inappropriate individuals. I further agree to maintain the confidentiality of Vidant Health proprietary information or other information which I have obtained by virtue of my service as an advisor. To this end, I agree to obtain Vidant Health consent prior to the release or disclosure of any such information to third parties, specifically including members of the media.

I understand that violation of this agreement may result in termination of my assignment at Vidant Roanoke-Chowan Hospital.

Teen Name (printed)	
Signature	
Parent/Guardian Name	
Parent/Guardian Signature	
Date	/ /