St. Elizabeth HEALTHCARE
Volunteer Services

# New Volunteer Teen Checklist

**Thank you for your interest in becoming a Volunteer at St. Elizabeth Healthcare! Please use this checklist as a guide to completing the required documents for volunteer service found in this packet.**

☐ **Characteristics of a St. Elizabeth Volunteer and Volunteer Agreement**
- o Please read and sign

☐ **Confidentiality Agreement**
- o Please read and sign

☐ **Parent/Guardian Consent and Agreement for Teen Volunteers**
- o Please read and sign; a Parent/Guardian must also read and sign

☐ **Reference**
- o Please have an adult non-family member complete this form (preferably a current teacher, school administrator or guidance counselor)

☐ **Initial Health Questionnaire**
- o Please complete and sign
- o Remember to obtain a copy of your Immunization Record (if applicable).

☐ **TB Parent Consent Form**
- o Please have a Parent/Guardian read and sign; this document grants permission for you to have an initial TB test at your placement appointment

☐ **Review the Medical Requirement listed below and obtain the necessary immunizations and/or records.**
- o We require proof of 2 Measles, Mumps and Rubella (MMR) and 2 Varicella immunizations, or proof that you have had the disease.

☐ **Complete the Online Volunteer Application**

☐ **Complete the Online Hospital Orientation**
- o **Go to www.stelizabeth.com/volunteertraining**
- o **Follow instructions given online**

☐ **Attend Placement Appointment and bring completed paperwork with you**

St. Elizabeth HEALTHCARE Volunteer Services

# Characteristics of a St. Elizabeth Volunteer and Volunteer Agreement

**Please *carefully* review the information provided below prior to signing.**

## Characteristics of a St. Elizabeth Volunteer*:*

### Committed

- Volunteers at St. Elizabeth take pride in giving their time and talents to the patient, guests and staff.
- Many volunteer positions require our Volunteers to commit to a regular volunteer shift, making them a reliable part of the St. Elizabeth team!

### Cooperative

- Volunteers at St. Elizabeth are there to support the staff; partnering with them to better the experiences of our patients and guests.
- Volunteers are responsible, adaptable and responsive, with a desire to serve. Our Volunteers are an integral part of the SEH team!

### Compassionate

- Volunteers at St. Elizabeth possess qualities essential to assisting patients and guests during a stressful and emotional time- friendly, compassionate, generous, honest, positive and responsive- They CARE!

### Competent

- Volunteers are provided with extensive hospital orientation and training that is specific to their Volunteer position.
- Volunteers are expected to be responsive to the ever changing healthcare environment by learning new skills and adapting to new approaches.
- Typically, due to the amount of training and processing, it takes a new Volunteer 2-3 weeks from application to their first day of volunteering.

## Volunteer Agreement:

In signing this Agreement you are acknowledging your understanding of the characteristics that can be found in a St. Elizabeth Volunteer as outlined above and your willingness to fulfill these characteristics in your service at St. Elizabeth. Your signature also acknowledges your recognition of and commitment to the minimum 6 months of volunteer service. Failure to complete this commitment will result in dismissal from volunteer service, and the Volunteer Services department will not issue a volunteer hours report or letter of recommendation. Additionally, you understand that falsification or significant omission of any information provided in the application process may be considered justification for immediate dismissal when discovered.

_____
Print Full Name

_____ _____
Signature Date

St. Elizabeth HEALTHCARE
Volunteer Services

**ST. ELIZABETH HEALTHCARE ASSOCIATE CONFIDENTIALITY / NON-DISCLOSURE AGREEMENT**

As a St Elizabeth Healthcare associate I am responsible for maintaining the confidentiality of information relating to patients/residents/clients and fellow associates. Unless it is necessary to complete my job responsibilities, information about the present condition, performance, or personal affairs of patients/residents/clients or other associates will not be repeated or discussed either inside or outside the Healthcare.

When confidential information must be discussed in the course of my work, I will use discretion to keep such conversations from being overheard by others who are not directly involved. I am aware that there are both state and federal laws that protect health information and other confidential information from unauthorized access. I also realize careless or thoughtless release of confidential information can result in disciplinary action, including termination and also could result in legal action being taken against St. Elizabeth Healthcare.

As a St. Elizabeth Healthcare associate I will be obligated to attend/complete training courses directed at ensuring my understanding of St. Elizabeth privacy policies in relation to protecting confidential information.

**Confidential information includes but is not limited to:**

1. Information about patient/resident/client's condition or treatment;
2. Aggregate clinical data;
3. Employee records;
4. Employee patient/resident/client records;
5. Marketing plans;
6. Product or service plans;
7. Strategies/forecasts;
8. Patient/resident/client lists; and/or
9. Financial information.

Confidential information can be obtained through hearing it, seeing it, viewing the medical record, or accessing it in the computer system.

**While creating, accessing and/or utilizing confidential information I agree to abide by the following:**

- I agree to keep confidential all information I access.
- I agree to access only the minimum necessary to perform my duty.
- I agree to access only that information for which there is a *"Business Need to Know."* I understand that my access may be monitored.
- I agree to keep my password confidential. I understand that providing my password to another individual may result in disciplinary action up to and including termination.
- I agree to protect data at all times, which includes data in electronic, paper, film, images, video or other forms. I will protect data during its creation, entry, processing, distribution, storage, and disposal.
- I agree to protect data from unauthorized access, modification, destruction or disclosure.
- I understand that upon my termination from St. Elizabeth my ability to access St. Elizabeth information will end. I agree that I will not attempt to access Healthcare systems or disclose any confidential information to any person or entity after my termination.

I have read this document and understand that my signature constitutes my acceptance of the terms of the ***"Confidentiality / Nondisclosure"*** agreement.

| | |
|---|---|
| | Volunteer Services |
| **Volunteer Name (Print)** | **Department** |
| **Volunteer Signature** | **Date** |
| **Social Security #/Associate ID #** | |

St. Elizabeth HEALTHCARE
Volunteer Services

# Parent/Guardian Consent and Agreement for Teen Volunteers

**Please *carefully* review the information provided below prior to signing.**

**Volunteer Teens Must*:***

- Be between14 years old and a senior in High School
- Have appropriate and reliable transportation
- Have the time to commit to 3-4 hours of service generally once a week
- Maintain a clean uniform and abide by dress code
- Complete all required paperwork prior to start date – including immunization record
- Abide by the policies, procedures and laws that govern the hospital(s)
- Understand and maintain patient confidentiality
- Have an interest in being in a medical environment, learning new skills and serving others

**Complete Mandatory Training**

- Hospital Orientation/Training Modules
- Optional Nursing Unit Training (offered 2 times per year)

**Time Commitment Requirement**

- Minimum of once a week (3-4) hours and a maximum of twice a week
- *Summer Program* – Commit to no more than 2 absences during the program, which runs from mid-May through mid-August
- *School Year Program* - Commit to volunteering a minimum of 6 months
- Notify the volunteer area supervisor when unable to volunteer

In signing this Agreement both the parent/guardian and teen are acknowledging your understanding of the requirements for being a teen volunteer as outlined above. The parent/guardian signature also grants permission for, and acknowledges your support of the teen named below to volunteer for St. Elizabeth Healthcare. Additionally, you understand that falsification or significant omission of any information provided in the application process may be considered justification for immediate dismissal when discovered.

☐ **Check here if give permission for your student's photo to be used by St. Elizabeth Healthcare for publicity or recruitment purposes**

*Thank you for your support. We look forward to working with you!*

_____
Print Full name of Teen

_____ _____
Parent/Guardian Signature Date

_____ _____
Teen Signature Date

St. Elizabeth HEALTHCARE Volunteer Services

# *TEEN VOLUNTEER REFERENCE FORM*

**859/301-2140**
**volunteer@stelizabeth.com**

_____ is considering volunteering at St. Elizabeth Healthcare. As a part of their application, a school/adult reference is required. Your name and email address have been supplied by the student as being willing to provide this reference. Please complete the form below.

**ALL INFORMATION IS CONFIDENTIAL**

Name of person completing reference_____

Position_____ School_____

Relationship to teen_____ Length of time known teen_____

Please briefly describe why you are recommending this teen to be a volunteer at St. Elizabeth:

_____

_____

Please tell us what your experience with the applicant has been by checking the appropriate box below.

| ***Applicant....*** | ***Superior*** | ***Good*** | ***Fair*** | ***Poor*** | ***Comments*** |
|---|---|---|---|---|---|
| **is dependable** | | | | | |
| **uses good judgment** | | | | | |
| **relates well to others** | | | | | |
| **presents neat appearance** | | | | | |
| **has patience with others** | | | | | |
| **accepts instruction** | | | | | |
| **gets the job done** | | | | | |
| **does quality work** | | | | | |
| **respects confidentiality** | | | | | |

Would you recommend this teen for volunteer placement in a hospital setting? ___yes ___no

Comments:_____

***Thank You!***

St. Elizabeth HEALTHCARE Volunteer Services

Edgewood Florence Ft. Thomas

# INITIAL HEALTH QUESTIONNAIRE FOR VOLUNTEERS

**PRINT NAME: _____ DATE OF BIRTH: _____**

**Please provide a copy of your Immunization Records in addition to completing this form.**

**HAVE YOU HAD THE FOLLOWING DISEASES?**

| | YES | NO | Don't know |
|---|---|---|---|
| Rubella…… | ☐ | ☐ | ☐ |
| Measles (10 day/old fashioned)..... | ☐ | ☐ | ☐ |
| Mumps……. | ☐ | ☐ | ☐ |
| Chicken pox……..… | ☐ | ☐ | ☐ |
| Tuberculosis ……... | ☐ | ☐ | ☐ |
| Have you had a positive TB skin test? | ☐ | ☐ | ☐ |
| Have you had close contact with anyone who has or has had TB? | ☐ | ☐ | ☐ |

**HAVE YOU HAD THE FOLLOWING IMMUNIZATIONS?**

**There are specific immunizations required for anyone (born after 1957) working or volunteering in a hospital facility. If you do not have these immunizations, we will be in contact with you to determine how you can complete this requirement.**

| | YES | NO | DATES (If Documented) |
|---|---|---|---|
| Tetanus/Diphtheria ……. | ☐ | ☐ | _____ |
| Influenza ……. | ☐ | ☐ | _____ |
| Varicella (Chicken Pox) ……. | ☐ | ☐ | _____ |
| Measles, Mumps, Rubella …….. | ☐ | ☐ | _____ |

**DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING SYMPTOMS?**

| | YES | NO |
|---|---|---|
| Productive Cough (3 weeks +)…… | ☐ | ☐ |
| Persistent weight loss……... | ☐ | ☐ |
| Persistent low grade fever…… | ☐ | ☐ |
| Night sweats……. | ☐ | ☐ |
| Loss of appetite…… | ☐ | ☐ |
| Coughing up blood…….. | ☐ | ☐ |
| Shortness of breath…….. | ☐ | ☐ |
| Chest pain…… | ☐ | ☐ |

**IF YOU MARKED "YES" TO ANY OF THE ABOVE SYMPTOMS, PLEASE COMMENT.**

_____

_____

**SIGNATURE OF VOLUNTEER:**

**X_____DATE:_____**

FOR EMPLOYEE HEALTH OFFICE USE ONLY
RECOMMENDATIONS:

_____

Signature of EHN:_____ Date:_____

St. Elizabeth HEALTHCARE
Volunteer Services

# Parent/Guardian Consent for TB Testing of Teen Volunteers

All active volunteers are required by the State of Kentucky to receive an initial and an annual TB test. Volunteers under the age of 18 must bring this completed form to receive the test at St. Elizabeth Healthcare.

☐ **Check here to give permission for your student to receive the required TB test**

_____
Print Full name of Teen

_____
Parent/Guardian Signature

Date _____