

LAST NAME: _____

DATE RECEIVED: _____

Washington Adventist Hospital
Teen Volunteer Application
7600 Carroll Avenue
Takoma Park, MD 20912
(301) 891-5444

PERSONAL INFORMATION

Name	Male or Female	Date
Telephone (Home)	(Work)	(Cell)
Address	E-Mail	
City	State	Zip Code
S.S. #	(or) Provide I-94 Card (Original)	Date of Birth

WORK EXPERIENCE

Currently Employed: Yes ____ No ____ Full-Time ____ Part-Time ____ Dates: _____	
Place of Employment	Reason for Leaving
Supervisor's Name	Telephone
Previous Employment	
Previous Volunteer Experiences	

EDUCATION

Currently Enrolled in School? Yes ____ No ____ Highest Level Completed? _____		
Name of School		
Address of School		
City	State	Zip Code
Fluent in what languages?		

VOLUNTEER INFORMATION

Why would you like to volunteer? Spare Time ____ School Requirement ____ Internship Requirement ____ Court Mandated ____ Other reason: _____
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Desired Choice of Volunteer Position: <i>(select check all areas of interest)</i> Patient Care ____ Office/Clerical Support ____ Gift Shop ____ Reception Desks ____ Other _____

Availability and Schedule: (circle choices) 1. Sunday Monday Tuesday Wednesday Thursday Friday Saturday 2. Mornings (8 a.m. – 12 noon) Afternoons (12 noon – 4 p.m.) Evenings (4 – 8 p.m.) 3. How many hours per week do you want to volunteer? _____ Minimum: 4 hours per week, Maximum: 16 – 20 hours per week 4. When do you want to volunteer? (select all that apply) <input type="checkbox"/> Year around <input type="checkbox"/> Summer - Start date _____, End date _____ <input type="checkbox"/> School Breaks - list preference _____

IN CASE OF EMERGENCY

Please Notify:	Relationship:
Telephone: Home () _____ Work () _____ Cell () _____	

REFERENCES

Please list two people who have known you longer than one (1) year. Please do not use the name of a relative.

Name _____ Phone () _____

Name _____ Phone () _____

May we have your permission to contact the two references you have listed? Y ___ N ___

HEALTH INFORMATION

Do you have any health restrictions do we need to be aware of? _____

Do you have any special needs do we need to make provision for? _____

Do you have any chronic illnesses, diseases or disabilities that might interfere with your service?

Y ___ N ___ If (yes), please explain briefly and state what accommodations you feel will be necessary:

Have you had a TB Test/Chest X-Ray within the last six (6) months? Y ___ N ___

(If yes, please provide a copy of the results for our records before your start date.)

VOLUNTEER PLEDGE

Believing that Washington Adventist Hospital has a real need for my services as a volunteer, I pledge to:

- Conduct myself with dignity and courtesy at all times
- Work harmoniously with others, using tact, understanding and compassion
- Treat all information concerning patients as confidential
- Be dependable in attendance, punctuality and performance of duties
- Exhibit loyalty to the hospital, upholding standards, attitudes, vision and mission which influence the reputation of Washington Adventist Hospital in the community
- Maintain a neat and clean professional appearance, keeping make-up and jewelry to a minimum and abiding by the volunteer dress code
- Abide by all hospital safety requirements

I agree to:

- Donate a minimum of 100 Hours of service to Washington Adventist Hospital within one calendar year
- Abide by all the guidelines in the volunteer manuals
- Perform my volunteer assignments without remuneration.

I understand any omission or misrepresentation of information in this application may result in refusal of or separation from my volunteer service at the hospital. I certify that I am NOT volunteering as a court referral or attorney referral.

I certify that I am at least 15 years of age.

TEEN SIGNATURE: _____ DATE: _____

PARENT SIGNATURE: _____ DATE: _____

VOLUNTEER HEALTH SERVICES INFECTION CONTROL QUESTIONNAIRE

Please answer the following questions. If you do not know the answer to a question, please try to find the answer by contacting your parent or physician. Since most of the diseases of concern are "childhood" diseases, you may have to contact your pediatrician if available. If you are unable to obtain information, check the "unknown" square. If you were born after 1956, you will be required to provide a copy of your MMR and Chicken Pox Vaccines. All schools require these vaccinations. Your cooperation in this matter is greatly appreciated.

NAME:	DOB:	AGE:	RACE:
ADDRESS: PHONE #:			
COUNTRY OF BIRTH: SS# :			
POSITION: Hospital Volunteer			
DATE OF LAST TB SKIN TEST:		RESULTS: (circle one) Negative (or) Positive	
HAVE YOU EVER HAD A CHEST X-RAY? (circle one) YES (or) NO			
If Yes, WHAT YEAR:			

Have you ever had any of the following diseases or been vaccinated against them?

DISEASE	Have you ever had:		Been Vaccinated Against:		
	Yes	No	Yes	No	Unknown
Chicken Pox / Shingles					
Measles (M)					
Mumps (M)					
Rubella (R) German Measles					
Pertussis					
Diphtheria					
Tetanus					
Tuberculosis (TB)					
Hepatitis B					
Polio					

Have you ever donated blood and then were told not to donate again? _____

If you have any brothers or sisters, have they ever had Chickenpox? _____

Have you done any foreign traveling within the past year? _____ If "Yes", where? _____

Have you ever been treated for pulmonary tuberculosis (INH) _____

Are you currently taking any immunosuppressive drugs such as prednisone? _____ If "Yes", what? _____

**Washington Adventist Hospital
Teen Volunteer Program
Authorization for Medical Treatment of Minor Children**

Immunization Records

If you do not have the immunization records for Measles, Mumps, Rubella and Chicken Pox, for your child, we are asking that you give your permission, indicated by your signature below, to allow the Occupational Health Department at Washington Adventist Hospital to do a simple blood test (at no charge to you or your child) to ensure they have sufficient immunity to work in a healthcare environment.

Parent/Guardian's Signature _____ Date _____

Permission for TB Testing and Emergency Treatment of a Minor

I certify that I am the natural parent or legal guardian of _____
He/She has my permission to volunteer at Washington Adventist Hospital and receive a TB Skin test and/or Chest X-Ray (at no charge) and I further give permission for the hospital to render treatment and hospital care to the said minor under the supervision and advice of our family physician Dr.

_____,
Dr.'s Phone Number _____, or if her/she is not available, the on-duty Emergency Department physician, when the need for such treatment is immediate as determined by him/her and when efforts to contact me are unsuccessful.

Parent/Guardian's Signature _____ Date _____

Liability Release

I hereby release Washington Adventist Hospital from any and all liability during such time as my child,
Name of Child _____ is participating in the Teen Volunteer Program at Washington Adventist Hospital.

Parent/Guardian's Signature _____ Date _____

Application Questionnaire

(Please complete all questions and return this form with your application)

Name: _____

Date: _____

Why did you choose Washington Adventist Hospital to volunteer?

Who referred you to our hospital?

Please describe any previous volunteer experiences.

Are you currently employed? What type of work?

Why would you like to volunteer?

Are you currently seeking employment?

Why did you leave your last employment?

What type of work do you enjoy?

What are your spare time activities, hobbies or talents?

What do you consider your greatest strength and weakness?

Do you have a specific position in mind?

Would you rather work with people or working alone?

What makes you feel good about your work at the end of the day?

Would you enjoy a fast-paced volunteer position or a calmer atmosphere?

Do you have any computer experience?

(continued)
Application Questionnaire Continued

When would you like to start volunteering?

Do you have any special needs or health restrictions we need to accommodate?

Have you ever been convicted of a felony?

Are you volunteering as a court or attorney referral?

If requested, are you willing to submit to a drug test prior to your acceptance into the volunteer program?

Are you willing to submit to a criminal background check?

Do you have any questions or concerns?

(These will be addressed during your interview with the Director of Volunteers.)

Can you agree to the below program requirements?

1. A commitment to a minimum of 100 hours of service
2. Complete Self-Study Preparation Materials (provided by Office of Volunteers)
 - 4 hours of Hospital Volunteer Orientation
 - On-the-job training
 - A Tuberculosis Screening Test
 - Abide by Hospital Uniform, always wearing jacket and I.D. badge while volunteering
3. Treat all customers of the hospital with respect and care. Customers often receive their first impression of the hospital through interaction with the volunteer. It is important that all volunteers take their role seriously.

Thank you for applying to volunteer at Washington Adventist Hospital!

Background Screening Disclosure and Consent

In connection with my application for volunteering with Washington Adventist Hospital, I understand that investigative inquiries may be obtained on my self and that any such report will be used solely for volunteer related purposes. I understand that the nature and scope of this investigation will include a number of sources including, but not limited to, criminal convictions, motor vehicle, and other reports. These reports will include information as to my character, general reputation, personal characteristics, mode of living, and work habits. Information relating to my performance and experience, along with reasons for termination of past employment from previous employers, may also be obtained. Further, I understand that you will be requesting information from various Federal, State, County and other agencies that maintain records concerning my past activities relating to my driving, criminal, civil, education, and other experiences.

I understand that if the Office of Volunteers at Washington Adventist Hospital accepts me, it may request an investigative report about me for volunteer-related purposes during the course of my service. The scope of this investigation will be the same as the scope of a pre-employment investigation, and that the nature of such an investigation will be my continuing suitability for volunteering or whether I possess the minimum qualifications necessary for promotion or transfer to another position. I understand that my consent will apply throughout my volunteer service, unless I revoke or cancel my consent by sending a signed letter or statement to the Office of Volunteers at Washington Adventist Hospital at any time, stating the I revoke my consent and no longer allow the Office of Volunteers at Washington Adventist Hospital to obtain investigative reports about me.

I understand that I am being given a copy of the "Summary of Your Rights Under the Fair Credit Reporting Act" prepared pursuant to 15 U.S.C. Section 1681-1681u. This Disclosure and Consent form, in original, faxed, photocopied or electronic form, will be valid for any reports that may be requested by the Office of Volunteers at Washington Adventist Hospital.

I authorize without reservation any party or agency acting on the behalf of Washington Adventist Hospital to furnish the above-mentioned information. I hereby consent to your obtaining the above information from:

Accurate Background, Inc.
6 Orchard, Suite 200
Lake Forest, CA 92630
800.216.8024

I understand to aid in the proper identification of my file or records the following personal identifiers, as well as other information, is necessary.

Your Legal Name:		
Last	First	Middle
List other names used (including maiden names, nicknames):		
E-mail address:		
Social Security Number: -- --	Home Phone:	
Date of Birth*:	Other Phone:	
Address:		
City:	State:	Zip:
Please list all United States Cities and States you have lived in for the past seven (7) years:		
Teen Signature:		Date:
Parent Signature:		Date:

*DOB is used only if identification purposes by Accurate Background, Inc.