Adventist HealthCare
White Oak Medical Center

TEEN VOLUNTEER APPLICATION

First Name	Last Name	Male/Female	Date
Home Phone	Cell Phone	Preferred Phone	
Address	Email	Want to receive our email newsletter? Y/N	
City	State	Zip Code	
Social Security #	or provide I-94 Card (Original)	Birth Month and Day	

Work Experience

Current or most recent employer:			
Position Held:	Part-Time_____Full-Time_____	Dates:	
Supervisor's Name:	Telephone:		
Reason for leaving:			
Describe any previous/current volunteer experience:			

Education

Name of Institution:	Highest Grade Completed:		
Address:	City:	State:	Zip:
Currently enrolled: Yes_____ No_____	Fluent in what languages:		

Volunteer Information

Why would you like to volunteer? Select all that apply.
Spare Time_____ School Requirement_____ Internship Requirement_____ Personal Enrichment_____
Court Mandated_____ Interest in healthcare_____ Other_____
I would like to volunteer during □ Summer or □ Year Around
Volunteer Position (select all areas of interest)
I would like to work with:
Computers_____ Patients_____ Public_____ Office Environment_____ Customer Service_____
I would **not** like to work with:
Computers_____ Patients_____ Public_____ Office Environment_____ Customer Service_____

Availability and Schedule (Indicate available time blocks) 4 hour shifts required

Day	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
A.M.							
P.M.							

IN CASE OF EMERGENCY
Name: Relationship:
Telephone: Home ( ) _____ Work ( ) _____ Cell ( ) _____

REFERENCES
Please choose two people who have known you longer than one (1) year that may be contacted. Do not use the name of a relative.
Name Phone ( ) _____
Name Phone ( ) _____

HEALTH INFORMATION

Do you have any health restrictions we need to be aware of? _____
Do you have any special needs 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 within the last six (6) months? Y ___ N ___
Have you had a Chest X-Ray within the last six (6) months? Y___ N___
(If yes, please provide a copy of the report for our records before your start date. This can serve in lieu of a TB skin test.)

VOLUNTEER PLEDGE

Believing that White Oak Medical Center 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 White Oak Medical Center 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;
- Donate a minimum of 100 Hours of service to White Oak Medical Center within one calendar year;
- Abide by all the guidelines in the volunteer manuals;
- Contact given department if unable to make regularly scheduled shift;
- Perform my volunteer assignments without compensation.

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
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? _____

White Oak Medical Center
Teen Volunteer Program
Authorization for Medical Treatment of Minor Children

Immunization Records

Please choose one of the following to submit:

- Immunization Records
- Infection Control Questionnaire (Previous page)
- 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 White Oak Medical Center 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 (name of child) _____. He/She has my permission to volunteer at White Oak Medical Center 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 if needed 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 White Oak Medical Center from any and all liability during such time as my child, (name of child)_____ is participating in the Teen Volunteer Program at White Oak Medical Center.

Parent/Guardian's Signature _____ Date _____

Application Questionnaire

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

Why are you applying to volunteer at White Oak Medical Center?

_____

What have you gained from previous volunteer or work experiences?

_____

Are you currently seeking employment?

_____

What type of work do you enjoy?

_____

Do you have a specific position in mind?

_____

Would you rather work with people or work alone?

_____

Do you need to begin volunteering by a specific date?

_____

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

_____

Have you ever been convicted of a felony? Y_____ N_____

Are you volunteering as a court or attorney referral? Y_____ N_____

If requested, are you willing to submit to a drug test

prior to your acceptance into the volunteer program? Y_____ N_____

Are you willing to submit to a criminal background check? Y_____ N_____

Do you have any questions or concerns? *(These will be addressed during your interview.)*

_____

_____

The White Oak Medical Center Volunteer program requires the following:

1. A commitment to a minimum of 100 hours of service
2. Complete Self-Study Preparation Materials (provided by Office of Volunteers)
   Minimum of 4 hours 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 White Oak Medical Center!

If you agree to these requirements listed above, please sign below.

Name: _____ Date: _____

Background Screening Disclosure and Consent

In connection with my application for volunteering with White Oak Medical Center, 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 White Oak Medical Center 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 White Oak Medical Center at any time, stating the I revoke my consent and no longer allow the Office of Volunteers at White Oak Medical Center 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 White Oak Medical Center.

I authorize without reservation any party or agency acting on the behalf of White Oak Medical Center 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 are needed by Accurate Background, Inc.