



Tuality Healthcare

Building a healthier community.

Tuality Healthcare Youth Volunteer Application

Name _____ Cell phone# _____

Home phone# _____ E-mail address _____

Address _____
Number & Street City State Zip

Date of Birth _____ Social Security # _____

School Attending _____ Grade _____

Do you have any physical conditions that would limit the type of work you are able to do? Yes _____ No _____ If yes, please explain:

Physicians Name _____ Phone _____

In Case of emergency, contact _____

Relationship _____ Phone _____

Parent's Name _____ Cell Phone# _____

Please list skills that you have: _____

Other than to help people, why do you want to volunteer for Tuality Healthcare? _____

AVAILABILITY

Please check the days you are available for a volunteer assignment:

MON _____ TUES _____ WED _____ THURS _____ FRI _____ SAT _____ SUN _____

Shift preferred: Morning _____ Afternoon _____ Evening _____

Consent for Minor To Participate in Volunteer Activities

This will authorize _____, a minor, to participate in such volunteer activities with Tuality Healthcare as may be prescribed by the hospital's representative. I understand that my daughter or son's services are donated to the hospital without contemplation of compensation or future employment.

I release the hospital and its employees from any claim of liability for the damages, injury or illness resulting to said minor, not occasioned by any fault or neglect on the part of the hospital, while participating in such volunteer activities.

This authorization shall remain effective until my son/daughter no longer volunteers with Tuality Healthcare. In the event of an emergency, every effort will be made to contact parent/guardian prior to any emergency medical treatment of said minor. In the event that I cannot be contacted, I, the undersigned parent/guardian do hereby authorize Tuality Community Hospital as agent to give EMERGENCY medical/surgical care, if needed, under the supervision of any physician/surgeon licensed by Tuality Healthcare whether such diagnosis or treatment is rendered at the office of said physician or at said healthcare facility. It is understood that this authorization is given in advance, to provide authority and power on the part of our aforesaid agent, to give EMERGENCY CARE which the aforementioned physician/hospital, in the exercise of his/her best judgment, may deem advisable.

Signature _____

Emergency Phone # _____

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I hereby give consent for my son/daughter _____ to volunteer with Tuality Healthcare. I will assume responsibility for his/her transportation to and from the hospital.

Parent/Guardian Signature

Date

As a Youth Volunteer, I agree that:

1. I will hold as absolutely confidential all information that I may obtain directly or indirectly concerning patients, doctors or personnel, and not seek to obtain confidential information from a patient.
2. My services are donated to the hospital without contemplation of compensation or future employment.
3. I will be punctual and conscientious, conduct myself with dignity, courtesy and consideration of others, and endeavor to make my work professional in quality.
4. I will attempt to resolve any problems related to my volunteer activities with my supervisor or the Volunteer Services Manager.
5. I will strive to fulfill my commitment to the hospital by completing all assignments that I accept.
6. I will uphold the philosophy and standards of the hospital at all times.
7. I understand that the Volunteer Services Department reserves the right to terminate my volunteer status as a result of:
 - a. Failure to comply with hospital policies and rules.
 - b. Absences without prior notification.
 - c. Unsatisfactory attitude, work or appearance.
 - d. Any other circumstances which are contrary to the best interests of the hospital.

I have read each of the above conditions and I agree to be bound by them.

Volunteer Signature

Date

Parent/Guardian

Date



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Honoring our patients' right to confidentiality is our ongoing commitment. Please help us meet this goal.

VOLUNTEER CONFIDENTIALITY STATEMENT

As a volunteer, I understand that I may come in contact with confidential information-both clinical and employee related through written records, documents, ledgers, internal verbal correspondence and communications, electronic programs and applications. I will not access, nor do I have the right to review or disclose personal information, medical or otherwise, except when fulfilling my job responsibilities.

I agree not to divulge or disclose to anyone other than those persons of the corporation who have the “need to know” directly or indirectly, either during or after my employment, any confidential information acquired during the course of my employment.

I understand and acknowledge that in the event I breach any provision of this agreement, Tuality Healthcare has the right to reprimand, suspend and/or terminate my volunteer work, with or without notice.

Please Use Ink

Volunteer Name (print)

Volunteer Signature

Date

**All information that you see and hear in the hospital, remains in the hospital; and is not shared with others in the hospital, unless it is information needed to do the job.
PUT A LID ON IT!**