



Community Hospital of San Bernardino

A member of CHW

Volunteer Services Junior Application Package



Junior Volunteer Program

Dear Interested Student:

Thank you for your interest in the Junior Volunteer Program at Community Hospital of San Bernardino. Attached is our application packet for you to complete.

The purpose of the Junior Volunteer Program is to provide non-clinical customer service to our patients, visitors and staff. The Junior Volunteer Program offers the opportunity to perform community service and provides an introduction to a variety of career choices in healthcare.

To be eligible for the Junior Volunteer Program, you must:

- ☞ Be a full-time student in the 9th through 12th grade
- ☞ Submit the completed application packet with all the requested attachments
- ☞ Have received at least a "B" in all classes as indicated on most recent report card
- ☞ Provide Junior Volunteer Personal Reference
- ☞ Copy of School Immunization record
- ☞ Copy of Student Identification/ Drivers License or small photo of yourself (no group photo)
- ☞ Completed Ethics Guidelines Agreement (be sure the form is signed by the applicant and parent/ legal guardian of the applicant)
- ☞ Completed Authorization for Consent to Treatment of a Minor signed by parents/ legal guardian
- ☞ Attend an interview session (by appointment)
- ☞ Complete R.S.V.P. Safety and Infection Control packet
- ☞ Purchase and maintain volunteer uniform. (Volunteer shirts are available for purchase in the Volunteer Center upon acceptance to the program)
- ☞ Consent to and clear the TB test administered by CHSB Employee Health Services
- ☞ Attend Orientation (by appointment)
- ☞ Be available to volunteer once a week for 3 to 4 hour volunteer shifts
- ☞ Commit to volunteer a minimum of 100 hours
- ☞ Commit to abide by the policies and procedures of Volunteer Services, including ethical guidelines for conduct and protecting patient confidentiality at all times
- ☞ Maintain a positive attitude and support the mission and values of Community Hospital of San Bernardino\

Upon receipt of your completed application and verification of the personal reference you will be contacted for an interview. Junior Volunteer Orientations are held periodically throughout the year based on need and available volunteer positions. When an orientation date is set, each student on file will receive an invitation for themselves and one of their parents to attend the next scheduled orientation. At the orientation, you will learn about the Junior Volunteer Program, the policies and procedures for Volunteers and you will be given your Volunteer assignment (depending on position availability).

For more information, please contact Carrie Schmidt, Manager Volunteer Services at 909.806.1260. Again, thank you for your interest in joining the Volunteer Program at CHSB. Volunteers touch lives and lift spirits every day in our hospital. We appreciate your interest in joining our team.



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JUNIOR VOLUNTEER PROGRAM APPLICATION CHECKLIST

Dear Interested Student,

Thank you for your interest in the Junior Volunteer Program of Community Hospital of San Bernardino.

To complete the first step of the application process, please return the following documents, signed and dated as appropriate:

- Junior Volunteer Application
- Junior Volunteer Personal Reference Form
- Copy of Report Card (most recent – no progress report)
- Copy of School Immunization Record (available from the school)
- Small photograph of yourself (no group photo)
- Ethics Guidelines Agreement – Junior
- Authorization for Consent to Treatment of a Minor
- Emergency Contact Information

Once the documents have been submitted and the personal reference has been verified, you will be contacted to schedule an interview. Upon acceptance into the volunteer program at the hospital, you will be required to complete the TB screening, volunteer orientation and the remainder of the volunteer application process.

Thank you once again for your interest in volunteering at Community Hospital of San Bernardino.

Carrie Schmidt
Manager Volunteer Services
Community Hospital of San Bernardino
909.806.1260
clschmidt@chw.edu

APPLICATION DATE:	DATE OF BIRTH:	SOCIAL SECURITY #:
_____	_____	_____ - _____ - _____
LAST NAME:	FIRST NAME:	MI:
_____	_____	_____
ADDRESS:	CITY:	ZIP CODE:
_____	_____	_____
HOME NUMBER:	CELL NUMBER:	EMERGENCY NUMBER:
_____	_____	_____
EMAIL ADDRESS:		

MOTHERS NAME:	BUSINESS PHONE NUMBER:	CHSB EMPLOYEE?
_____	_____	<input type="checkbox"/> NO <input type="checkbox"/> YES
IF CHSB EMPLOYEE, STATE DEPARTMENT:		SUPERVISOR, IF KNOWN
_____		_____
FATHERS NAME:	BUSINESS PHONE NUMBER:	CHSB EMPLOYEE?
_____	_____	<input type="checkbox"/> NO <input type="checkbox"/> YES
IF CHSB EMPLOYEE, STATE DEPARTMENT:		SUPERVISOR, IF KNOWN:
_____		_____

SCHOOL YOU ATTEND:	ADDRESS:	TELEPHONE NUMBER:
_____	_____	_____
LIST SCHOOL ACTIVITIES YOU PARTICIPATE IN:		

ARE YOU CURRENTLY EMPLOYED?	IF YES, SPECIFY WHERE:	
<input type="checkbox"/> NO <input type="checkbox"/> YES	_____	
OTHER LANGUAGE(S) YOU SPEAK?		

LIST ANY VOLUNTEER EXPERIENCE:

PLEASE STATE THE REASON(S) YOU WANT TO VOLUNTEER AT CHSB:

JUNIOR VOLUNTEER SIGNATURE:	DATE APPLICATION SIGNED:
_____	_____

PARENT OR LEGAL GUARDIAN CONSENT

I give permission for my son/ daughter to participate and be a member of the Community Hospital of San Bernardino Junior Volunteer Program. I understand that he/ she is volunteering his/ her services to the hospital solely for his/ her personal purposes or benefit without promise or expectation of compensation or hospital benefits. I understand and agree that he/ she may be dismissed for failure to abide by the policies and procedures, including to hold strictly confidential all medical information obtained directly or indirectly concerning customers (patients). I also give permission for my son/ daughter to submit to tuberculin skin test (P.P.D. Mantoux) and the Rubella Titer, if needed, which are requirements for all volunteers and hospital employees.

PARENT OR LEGAL GUARDIAN SIGNATURE:	DATE APPLICATION SIGNED:
_____	_____

DATE APPLICATION RECEIVED:	APPLICATION RECEIVED BY:	DEPARTMENT:
_____	_____	_____



JUNIOR VOLUNTEER PERSONAL REFERENCE

INSTRUCTIONS: Applicant is to complete the top portion of the form.
Request that the person providing the reference complete the section *How This Student is Observed*.
Return the completed form to the Manager of Volunteer Services.

Date of Request: _____

Volunteers Name: _____

Street Address: _____

Name of School: _____ **Grade:** _____

Date of Volunteer Assignment: _____ **Department Assigned:** _____

Hours Completed: _____

The above named volunteer must be a mature and responsible person to volunteer in a hospital. This reference serves as verification of the volunteer applicant to perform volunteer service.

OBSERVATIONS OF THE STUDENT

Observed Performance	Exceptional	Above Average	Average	Below Average
Willingness to work				
Honesty				
Dependability				
Speech				
Appropriateness of dress				
Manners				
Accepting directions				
Following directions				
Social Interaction				

Additional comments about strengths or areas of improvement that have been observed about the student:

Name of Person Completing Form (Please print)	Signature of Person Completing Form
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Department/ Title	Telephone Number	Date
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Manager Volunteer Services Approval	Date
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ETHICS GUIDELINES AGREEMENT – JUNIOR

If accepted as a hospital 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. I am volunteering my services and there is no pay involved in the assignment.
3. I understand it is a crime to solicit business for attorneys. I will not solicit any business for attorneys or insurance companies on hospital property, or act as a runner or carrier for an attorney in the solicitation of business. I will report all known occurrences of solicitation for attorneys to the hospital Volunteer Manager.
4. I will not sell or attempt to sell goods or services, request contributions, or solicit persons to sign or distribute political petitions or religious material on hospital premises, unless I receive the express authorization of the hospital Volunteer Manager to engage in these activities.
5. I will, if requested, submit to examinations, which may include chest x-rays, skin tests, approved laboratory tests, and/ or immunizations that may be necessary as part of my volunteer service. If requested, I hereby authorize my doctor(s) to furnish the hospital information concerning my health. I also authorize the person(s) making x-ray films to report the results to the hospital
6. I shall be on time and conscientious, conduct myself with dignity, courtesy and consideration of others, endeavor to work as a professional and will speak and act in this manner at all times. I will keep a quiet voice.
7. I will attempt to resolve any problems related to my volunteer activities with my immediate department supervisor, and if unsuccessful, attempt to resolve any such problems in the matter with the Manager of Volunteer Services.
8. I will make my best effort to fulfill my commitment to the hospital by completing all assignments that I accept.
9. I will at all times uphold the philosophy and standards of the hospital.
10. I understand that the Volunteer Service Department reserves the right to terminate my volunteer status as a result of (a) failure to comply with hospital policies, rules and regulations; (b) absences without prior notification; (c) unsatisfactory attitude work or experience; or (d) any other circumstances which, in the judgment of the department director or hospital, would make my continued services as a volunteer contrary to the best interest of the hospital.

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

Volunteer Signature _____ Date _____

Parent/ Legal Guardian Signature _____ Date _____

Manager Volunteer Services Signature _____ Date _____

WHAT DAYS/ TIMES ARE YOU AVAILABLE TO VOLUNTEER?

Monday through Friday: Morning (8am – 12 Noon) Afternoon (12 Noon – 4pm) Evenings (4pm – 8pm)
 Saturday: Morning (10am – 12:30pm) Afternoon (12:30pm – 3:00pm)
 Do you have special skills? Computer Typing Other _____

VOLUNTEER SERVICES ONLY BELOW THIS LINE

Application RSVP Packet Report Card Drivers License/ School ID Immunization Record
 Interview TB Skin Test HIPPA Background Check Orientation
 T-Shirt Size _____ ID Badge Department Notified
 Assignment/ Department: _____ Start Date: _____



AUTHORIZATION FOR CONSENT TO TREATMENT OF A MINOR

I, the undersigned parent/ legal guardian of _____, a minor, do hereby authorize Community Hospital of San Bernardino's Emergency Department and Medical Staff as agent(s) for the undersigned to consent to any x-ray examination, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any physician and surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any hospital, whether such diagnosis or treatment is rendered at the office of said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, judgment may deem advisable.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

I hereby authorize any hospital, which has provided treatment to the above named minor pursuant to the provision of Section 25.8 of the Civil Code of California to surrender physical custody of such minor to my above named agent(s) under the completion of treatment. This authorization is given pursuant to Section 1283 of the Health and Safety Code of California.

These authorizations shall remain effective until said minor is no longer in the Junior Volunteer Program at Community Hospital of San Bernardino.

Minor's Name (Please **PRINT**)

Parent/ Legal Guardian (Please **PRINT**)

Parent/ Legal Guardian (Please **SIGN**)

Print Home Address

City, State, Zip

Home Telephone Number

Work or Alternate Phone Number

Minor's Date of Birth

Minor's Social Security Number

Name of Minor's Physician/ Phone Number

Today's Date



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VOLUNTEER EMERGENCY CONTACT INFORMATION

Dear Volunteer,

In order to ensure that we have the most recent and accurate emergency contact information on file, we are requesting that the following information be completed and returned along with your application package to the Manager of Volunteer Services.

Thank you.

Name: _____ Phone Number: _____

Address: _____ City/ Zip Code: _____

Mailing Address, if different from above:

Date of Birth: _____

Marital status, spouses name and anniversary completed if applicable:

Marital Status: _____ Spouses Name: _____

Anniversary: _____

IN CASE OF EMERGENCY PLEASE NOTIFY:

Name: _____ Phone Number: _____

Relationship: _____ Alternate Number: _____

Name: _____ Phone Number: _____

Relationship: _____ Alternate Number: _____

Physician's Name: _____ Phone Number: _____