Scenic Mountain Medical Center
A STEWARD FAMILY HOSPITAL
Steward

JUNIOR VOLUNTEER APPLICATION

PLEASE PRINT **Date: _____**

Applicant Name: _____
First Middle Last

Age: _____ Birth Date: _____ Applicant Cell Phone: _____

Address_____ Phone: _____
(Applicant's) Number & Street Name City Zip Code

E-mail address: _____ /_____
Applicant's Parent's

Legal Guardian/Mother/Father Name: _____
(Both, if applicable) First Middle Last

_____
First Middle Last

Parent Phone _____ Parent Phone_____

In case of emergency notify: _____ Phone: _____

Shirt Size (polo type): Youth **M** **L** Adult **S** **M** **L** **XL** **2X** **3X**

Name of School: _____

Circle One: Freshman Sophomore Junior Senior

Hobbies/Clubs/Interests: _____

How did you learn about the Junior Volunteer Program at Scenic Mountain Medical Center?
_____

Why would you be a good volunteer?
_____
_____

Do you have any physical handicaps? □ YES □ NO
If yes, please explain: _____

Volunteer Signature: _____Date_____

Parent/Legal Guardian Signature: _____Date_____
(Parent/Legal Guardian signature is required.)

By signing this application, you authorize the named volunteer applicant to receive Drug and TB Testing, and acknowledge that you have read and understand the Scenic Mountain Medical Center Junior Volunteer Standards of Conduct.

Scenic Mountain Medical Center
A STEWARD FAMILY HOSPITAL

JUNIOR VOLUNTEER SERVICES STANDARDS OF CONDUCT

AS A HOSPITAL VOLUNTEER, I AGREE THAT:

1. I shall 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, and given with humanitarian or charitable reasons.

3. I understand that it is a crime to solicit business for an attorney. I shall not solicit business for attorneys or insurance companies, both on or off hospital property, or act as a runner for an attorney in the solicitation of business. I shall report all known occurrences of solicitation for attorneys to the Volunteer Coordinator.

4. I shall not sell or attempt to sell goods or services, request contributions, or solicit persons to sign or distribute political petitions on hospital premises, unless I receive the express authorization of the Volunteer Services Coordinator to engage in these activities.

5. I shall submit to examinations, which includes tuberculosis skin tests and/or chest x-rays and a drug test as part of my volunteer service.

6. I shall be punctual and conscientious, conduct myself with dignity, courtesy and consideration of others, and endeavor to make my work professional in quality.

7. I shall attempt to resolve any problems related to my volunteer activities with my supervisor, and if unsuccessful, attempt to resolve any such problems with the Volunteer Services Coordinator.

8. I shall make my best effort to fulfill my commitment to the hospital by completing all assignments that I accept.

9. I shall at all times uphold the philosophy and standards of the hospital.

10. I understand that the Identification Badge issued to me is the property of the hospital, and I agree to return it upon leave of absence, termination of volunteer service or whenever requested by staff to do so.

11. I understand that the Junior Volunteer Services 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 appearance; or
    (d) other circumstances which, in the judgment of the Volunteer Services Coordinator, would make my continued service as a volunteer 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

Scenic Mountain Medical Center
A STEWARD FAMILY HOSPITAL

Steward

Authorization for Drug Test

It is the practice of Steward Healthcare to have a Drug Free Workplace. I understand that it is Steward Healthcare's practice to administer drug tests under certain conditions, as described in the Drug Free Workplace policy, to achieve the goals established by the policy. I hereby voluntarily consent to a drug test and authorize Scenic Mountain Medical Center to collect a blood or urine sample for the purpose of conducting the test. I understand and agree that the sample will be submitted for analysis to a laboratory designed by Scenic Mountain Medical Center and that Scenic Mountain Medical Center will pay for the test. I further authorize the laboratory to release the results of the drug test to the individuals at Scenic Mountain Medical Center designated to receive and/or responsible for such results. I understand that IASIS will abide by all legal obligations regarding the confidentiality of the test results. I understand that I will be given a copy of this Authorization upon request.

I understand that the drug test will be conducted to determine the presence of certain drugs and substances prohibited by law and/or company policy. Accordingly, I understand that if the drug test indicates the presence of a prohibited drug or substance, I may be subject to corrective action, up to and including immediate termination of volunteer time. I understand that I will be given the opportunity to explain any positive results before any corrective action is taken.

List and provide a copy of doctor prescription for routine medications:

_____

_____

_____

I further understand that, subject to any limitation imposed by law, a refusal to provide a sample under the conditions described in the Drug Free Workplace policy may result in corrective action, up to and including immediate termination of volunteer time.

_____ _____

Volunteer - Signature Parent - Signature if Volunteer is Under 18

_____ _____

Volunteer - Print Name Date

_____

Date

Scenic Mountain Medical Center

A STEWARD FAMILY HOSPITAL

Steward®

Parent/Legal Guardian Waiver

By signing below, I give Scenic Mountain Medical Center permission to contact the Junior Volunteer Recommendation Letter Reference provided with the application. I further agree that I have read and understand the Scenic Mountain Medical Center Junior Volunteer Program Standards of Conduct and Confidentiality Agreement.

_____

Name of Volunteer Applicant **Print**

_____

Legal Guardian/Parent **Signature**

_____

Legal Guardian/Parent **Print Name**

_____

Date

Scenic Mountain Medical Center
A STEWARD FAMILY HOSPITAL

JUNIOR VOLUNTEER EMERGENCY MEDICAL FORM

INFORMATION WILL BE KEPT CONFIDENTIAL

Full Name _____ Date of Birth _____

Address _____

Emergency Contact _____ Cell Phone_____

Parent/Guardian Name _____

Daytime Phone _____Cell Phone _____

Health/Medical Insurance Company _____

Physician _____Phone _____

Medication /Allergies: _____

Other Allergies: _____

Special Needs/Physical Limitations:_____
_____

Current Medications: _____
_____

Other Health
Conditions/Information:_____
_____

_____ _____
Volunteer Signature Date

_____ _____
Parent Signature Date

Scenic Mountain Medical Center
A STEWARD FAMILY HOSPITAL

CONFIDENTIALITY AGREEMENT

Volunteer Name _____

As an SMMC Volunteer, I agree to follow all rules, policies, and procedures of Scenic Mountain Medical Center to the best of my ability.

I agree to respect the confidential nature of all records and any personal contact I may have with patients. I will adhere to all rules, policies, and procedures pertaining to confidentiality regarding all files and identification of patients, former patients, or potential patients for which I come in contact. I will treat all information about any patient as absolutely confidential.

I understand that I am expected to act in a professional manner while maintaining confidentiality at all times including handling of records, participation with projects or conversations. I agree I will abide by the obligations of contractual confidentiality agreements, including but not limited to conversations, computerized information, and patient charts.

I understand that patient information is not to be accessed, altered, removed, discussed with or disclosed to unauthorized persons, either within or outside the hospital. Specifically, I further understand that information regarding a patient's identity, diagnosis, or treatment should never be discussed inside or outside of my volunteer placement.

Additionally, I understand that I am prohibited from having unauthorized possession of confidential records or disclosing information contained in confidential records to unauthorized persons. I understand that I am also prohibited from disclosing confidential information to unauthorized third parties.

I am aware that any breach of this trust will result in dismissal from the SMMC Junior Volunteer Program. I understand that a violation of this confidentiality requirement could result in other appropriate disciplinary and/or legal action being initiated.

Additionally, I will report any known or suspected breaches of confidentiality to the SMMC Volunteer Program Coordinator.

Scenic Mountain Medical Center
A STEWARD FAMILY HOSPITAL

Steward

CONFIDENTIALITY AGREEMENT

Signature Page

I read and fully understand the SMMC Confidentiality Agreement.
I agree to abide by it and understand the consequences if I do not.

_____
Volunteer Name (PRINTED)

_____ _____
Volunteer Signature Date

_____
Parent Name (PRINTED)

_____ _____
Parent Signature Date

(2 of 2)

Scenic Mountain Medical Center

A STEWARD FAMILY HOSPITAL

Steward

Tuberculosis PPD Worksheet for Volunteers

Name (Print) _____ Date_____

☐ Yes ☐ No Have you ever had a positive reaction to a TB skin test?

☐ Yes ☐ No Have you received the BCG vaccine? (TB vaccine not given in U.S.)

☐ Yes ☐ No Flu, measles or rubella vaccine received in last 6 months?

☐ Yes ☐ No Viral infection (time lost from work during last month)?

☐ Yes ☐ No Severe illness with fever during last month?

☐ Yes ☐ No Taking cortisone or other immunosuppressives?

☐ Yes ☐ No Have you ever had TB?

☐ Yes ☐ No Known contact with person with active TB in last few months?

☐ Yes ☐ No This will be my first test.

☐ Yes ☐ No (For females)Currently pregnant?

_____

Volunteer Signature **Date**

***If under 18, must have parent/legal guardian signature:**

***** _____

Parent/Legal Guardian Signature

Clinical Use Only FIRST TEST

PPD: Date Given:_____ _Lot #_____
Intradermal Site_____ Given By_____

Results of Test:
_____ zero - No redness or swelling
_____ mm - redness only (No swelling)
_____ mm – Swelling with redness (measure swelling only)
Test read by_____ Date_____

Clinical Use Only SECOND TEST

PPD: Date Given:_____ Lot #_____
Intradermal Site_____ Given By_____

Results of Test:
_____ zero - No redness or swelling
_____ mm - redness only (No swelling)
_____ mm –Swelling with redness (swelling only (mm)

Test read by_____ Date_____

***FOR CHEST X-RAY:** Date done: _____ ***When a TB Test can not be performed**

Referred To: ☐ **County Health** ☐ **Personal Physician**

Employee Health Practitioner_____

Scenic Mountain Medical Center

A STEWARD FAMILY HOSPITAL

Steward

SMMC Junior Volunteer Summer Program

Application Check List

1. Completed Junior Volunteer Application Form. ☐
2. Completed Standards of Conduct Form ☐
3. Authorization for Drug Testing Form ☐
4. Completed Parent or Legal Guardian Waiver Form. ☐
5. Completed Jr. Volunteer Emergency Medical Form. ☐
6. Confidentiality Agreement signed by both student & parent. ☐
7. Tuberculosis PPD Worksheet for Volunteers ☐
8. A Copy of Report card (must maintain a "B" average or higher) for the Fall or Spring semester. ☐
9. Provide a Current (up-to-date) immunization record. ☐
10. A Copy of picture identification such as driver license or school identification. ☐
11. Recommendation letter from a school counselor/teacher, minister, or hospital employee (Someone other than a family member.) Not required for last year's volunteers. ☐
12. Submit complete application to: ☐

    Administration office attention: April Arms
    Or mail to: Scenic Mountain Medical Center
    Junior Volunteer Program
    1601 W 11th Place
    Big Spring, Tx 79720

    Or email to: april.arms@steward.org

Volunteer Programs Coordinator at 432-268-4907

Scenic Mountain Medical Center
A STEWARD FAMILY HOSPITAL

Steward®

IMMUNIZATION FORM for Junior Volunteer
Or Provide Copy of Your Shot Record

Full Name _____

Date of Birth _____ Phone _____

Vaccinations:
Please indicate whether the individual stated above has been vaccinated against any of the following diseases.

	YES	DATE	NO
Tetanus	____	_____	____
Hepatitis B	____	_____	____
Mumps	____	_____	____
Measles/Rubella	____	_____	____
Positive Skin Test for TB	____	_____	____
Chicken Pox/Varicella	____	_____	____

_____ _____
School Nurse/Physician Signature Date

Contact Person: Volunteer Programs at 432-268-4907

Scenic Mountain Medical Center
A STEWARD FAMILY HOSPITAL

Junior Volunteer Program

Questions & Answers

1. **How do I apply for the Scenic Mountain Medical Center Junior Volunteer Program?**
   The total process involves the application packet, tuberculosis and drug screening check and a mandatory orientation.

2. **Must I attend the scheduled orientation?**
   Yes, the orientation is mandatory including a TB Check that will require you to return in two days to be read. A parent is *highly encouraged* to attend the first hour of the orientation for important program information. Call the Volunteer Coordinator for the date and time.

3. **Do I have to participate in hospital drug testing?**
   Yes. SMMC provides a urine analysis as part of the volunteer screening policy at no cost to the Junior Volunteer. Offsite drug testing is not permitted.

4. **Do I have to wear a uniform?**
   Yes. SMMC provides a polo shirt and identification badge. Volunteers are required to wear closed toe, low heel or flat shoes (clean tennis shoes are permitted); white or black socks, and khaki pants or khaki skirt (must be below knee). More information about the SMMC dress code will be provided at the orientation.

5. **Can I help with emergencies or watch surgery?**
   Not usually. SMMCJunior Volunteers offer support and help for guests, visitors, and staff with tasks such as: Hospital greeter, escort patients, general office duties, prepare packets, check expired items, run errands within the hospital campus, and/or assist with water/linens/call lights for patients and assist the Auxiliary. **The following are not typical tasks or activities:** Observe surgical procedures**,** have contact with infants and/or and work on computers

6. **When can I volunteer? How much must I volunteer?**
   This is an 8 week program in which volunteers are expected to serve a minimum of 32 hours during the 8 weeks. Shifts are available **Monday through Friday between 8:15 am and 4:45 pm**. Shifts can be 4 or 8 hour days. No shifts will be available outside of these times, unless there is a hospital sanctioned event taking place that is in need of volunteers.

7. **What about meals?**
   Each Junior Volunteer has the option of taking one meal, a breakfast or lunch break when working a shift at least two hours in length. Breakfast is available from 7 AM – 9 AM, and lunch is served from 11AM – 1PM. There is no charge for the meal; drink included. Meals should be taken in the cafeteria after you have made arrangements with your cooperating SMMC Employee. Please note: Meal time does not count towards your hours.

8. Can I smoke on the SMMC campus?

No, is SMMC strictly a Tobacco Free Campus, including smokeless tobacco and e-cigarettes.

9. May I use my cell phone while volunteering?

Cell phones are allowed yet must not be in use while obtaining volunteer service hours.

10. **Will I automatically be accepted to the SMMC Jr. Volunteer Program?**

While all applications will be reviewed, *there are a limited number of volunteers accepted each summer*. Applicants will receive notification by mail or phone of program concerning acceptance.