SOUTHEAST GEORGIA HEALTH SYSTEM

# Volunteen Program Application Packet 2018

The Volunteen program is for teenagers, 14 through 18 years old, who enjoy helping others and want to learn more about health care and volunteerism. Applicants must be in good academic standing, capable of maintaining confidentiality, reliable, responsible and trustworthy.

Volunteens can be found volunteering in many departments throughout the Health System performing light clerical tasks and providing assistance to our team members, patients and guests. Volunteering is a great way for students to explore healthcare careers as well as earn the volunteer hours required for many college and scholarship applications.

Graduating high school seniors who have successfully served at least 20 hours of volunteer service through the Volunteen program and who are going on to pursue careers in healthcare may apply for one of the Auxiliary scholarships offered at both campuses.

**Volunteen Program Requirements**

- **Complete Volunteen Application and submit it prior to April 1**
- **Be 14 to 18 years old and enrolled in school**
- **Be able to commit to at least one, four-hour shift each week (20 hours of service minimum) during the summer session June – July.**
- **Attend a Pre-Orientation session with a parent or guardian at the Brunswick Campus, April 19 at 6:00 p.m. or at the Camden Campus, April 23 at 6:00 p.m.**
- **Have parental consent**
- **Provide a reference from a teacher or guidance counselor to be submitted with application (reference form is attached)**
- **Pass a background check**
- **Attend Volunteen Orientation at the Brunswick Campus, May 30 & June 1, 8:00 a.m. – 12:00 p.m. or at the Camden Campus, June 4 & June 6, 8:00 a.m. – 12:00 p.m. (mandatory attendance for both days of orientation)**
- **Complete a tuberculosis skin test administered during Volunteen Orientation.**

**Students participate in the summer session initially and after completing 20 hours of service students may volunteer during the school year after school and on weekends upon approval from the Director, Volunteer Services. Students who volunteer between Nov. 1 – Mar. 31 must also provide documentation of having received a flu vaccination by Nov. 15 annually.**

**To apply for the upcoming summer session:** Complete all portions of this application and return it to the Volunteer Services office at the appropriate campus by April 1. Incomplete applications will not be processed. Space in the program is limited and applications are processed in the order received. Once your application has been processed you will be contacted to confirm receipt and your attendance at the Pre-Orientation session.

**Questions?** Contact the Volunteer Services office at (912) 466-3157 Brunswick Campus, (912) 576-6405 Camden Campus or via email at kdoll@sghs.org or chowser@sghs.org.

SOUTHEAST GEORGIA HEALTH SYSTEM

# Volunteen Program Application 2018

The Volunteen program at Southeast Georgia Health System is for students ages 14-18 who are in grades 9-12. Applicants must be in good academic standing, capable of maintaining confidentiality, reliable, responsible and trustworthy. Students participate in the summer session initially and after completing 20 hours of service may volunteer during the school year after school and on weekends upon approval from the Director, Volunteer Services. Space in the program is limited and applications are processed in the order received. ***Applications are due before April 1.*** Questions? Contact the Volunteer Services office at 912-466-3157 Brunswick or 912-576-6405 Camden.

## PERSONAL INFORMATION

First Name: _____ Middle Initial: ____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____

I am applying to volunteer at the following campus: Brunswick ____ Camden ____

## EMERGENCY INFORMATION

In case of an emergency, who should we notify? _____

Relationship: _____ Phone: (____)_____

## EDUCATION/COMMUNITY INVOLVEMENT

School: _____ Grade: _____

List any healthcare courses, school activities, clubs, honors, sports, etc. you currently participate in

_____

Do you have plans to continue your education after high school? If yes, what course of study do you want to pursue? _____

List any community affiliations (church, civic groups, etc.) _____

_____

If you are seeking to volunteer as a requirement for any of the above activities/groups, please explain. Include the number of hours required and the date you must have them done by if necessary. _____

_____

Have you ever volunteered before (school, civic group)? If yes, please explain. _____

_____

**OTHER**

How did you hear about the Volunteen Program? _____

_____

Briefly explain why you want to join our Volunteen Program. _____

_____

What qualities or skills do you have that you think would make you a good volunteer? _____

_____

Are you interested in volunteering for the summer only or year around?

_____ Summer Only ____ Year Around

Do you have any friends, relatives, acquaintances employed by or volunteering at Southeast Georgia Health System? If yes, please list:

Name Position Relationship

_____

_____

If selected as a member of the Volunteen Program at Southeast Georgia Health System, I agree to observe the program's dress code requirements at all times while on Health System premises. I further agree to observe the Health System's confidentiality requirements, maintain a high standard of conduct, and observe all Health System rules and regulations. I pledge that I will represent myself, and my school, to the best of my ability. I understand that failure to abide by these requirements will result in my termination from the Volunteen Program.

Student's signature: _____ Date: _____

Please mail your completed application to:

**Brunswick Campus**:
Southeast Georgia Health System
Attn: Volunteer Services
2415 Parkwood Drive
Brunswick, GA 31520

**Camden Campus**:
Southeast Georgia Health System
Attn: Volunteer Services
2000 Dan Proctor Drive
St. Marys, GA 31558

SOUTHEAST GEORGIA
HEALTH SYSTEM

# Consent to Volunteer Form

As the parent/legal guardian of _____, I do hereby give my permission
Name of student

for him/her to participate in the Volunteen Program at Southeast Georgia Health System.
As a member of the Volunteen Program, I understand that my child will be required to:

1. Attend a Pre-Orientation Session with me at the Brunswick Campus on April 19 at 6:00 p.m. or at the Camden Campus on April 23 at 6:00 p.m.
2. Attend and complete both days of mandatory orientation at the Brunswick Campus on May 30 & June 1 from 8:00 a.m. – 12:00 p.m. or at the Camden Campus on June 4 & June 6 from 8:00 a.m. – 12:00 p.m.
3. Undergo a tuberculosis skin test (which will be administered to your child at no cost). I give my permission for this skin test to be performed.
4. Purchase a Volunteen Program uniform (polo-style Volunteen shirt*, khaki pants and closed-toed shoes such as tennis shoes). The Volunteen shirts are purchased through the Volunteer Services department for $15 each and the pants and shoes may be purchased from a retailer of your choice.
5. Wear the Health System identification badge at all times while on Health System premises and return the I.D. badge to Volunteer Services by August 15.
6. Volunteer at least one four hour shift per week during the summer session. Must complete a minimum of 20 hours of volunteer service during the summer session.
7. Maintain a high standard of conduct.
8. Comply with guest, visitor, and patient confidentiality policies.
9. Observe all Health System policies and procedures as well as rules and regulations.
10. Call both the assigned department and Director of Volunteer Services in the event of an emergency which prevents him/her from appearing for his/her assigned shift. Three unexcused absences will be cause for dismissal.
11. Provide documentation that he/she has received the influenza vaccine by Nov. 15 if he/she volunteers during flu season (calendar months for compliance will be designated by the Health System).

I understand that my child's failure to abide by any of the above Volunteen Program rules and regulations will disqualify him/her from further participation in the program. I further understand that participation in the Volunteen Program is strictly voluntary. No certification or degree of any kind is implied or awarded to its participants upon completion of the program.

_____ _____

Signature of parent or legal guardian Date

*No student will be denied participation due to inability to pay for a Volunteen shirt. Please contact the Director of Volunteer Services for additional information.

SOUTHEAST GEORGIA HEALTH SYSTEM

# Personal Reference Form

Name of Applicant: _____

I am submitting an application for participation in the Southeast Georgia Health System's Volunteen Program. I cannot be considered for participation until my references have been verified and are on file.

Name of Person Providing Reference: _____
**Reference should be from a teacher or guidance counselor, not a family member.*

Street Address: _____

City/State/Zip Code: _____

Telephone: _____ Email: _____

| | Outstanding | Above Average | Average | Below Average | Unsatisfactory |
|---|---|---|---|---|---|
| **Enthusiasm** | | | | | |
| **Willingness to assist others** | | | | | |
| **Academic standing** | | | | | |
| **Ability to maintain strict confidentiality** | | | | | |
| **Ability to work as part of a team** | | | | | |

Relationship to applicant: _____

How long have you known the applicant: _____

Additional comments regarding applicant (continue on back or add additional pages if needed):
_____

Signature: _____ Date: _____

Please complete the information above and mail it at your earliest convenience the appropriate address below. (Applicant please check the campus where you will be volunteering.)

_____ **Brunswick Campus**:
Southeast Georgia Health System
Attn: Volunteer Services
2415 Parkwood Drive
Brunswick, GA 31520
(912) 466-3157

_____ **Camden Campus**:
Southeast Georgia Health System
Attn: Volunteer Services
2000 Dan Proctor Drive
St. Marys, GA 31558
(912) 576-6405

SOUTHEAST GEORGIA
HEALTH SYSTEM

# CONFIDENTIALITY STATEMENT

As a Volunteer or Volunteen at Southeast Georgia Health System, I do hereby certify that I will respect the confidentiality rights of every guest, patient, and visitor who interacts with any department or unit within the Health System. I understand that the confidentiality of guest, visitor, and patient information is strictly maintained to protect the privacy rights of the individual. I pledge that I will not discuss or otherwise communicate any form of information concerning the care, condition, or treatment of any person(s) within the Health System.

I understand that failure to abide by the confidentiality requirements will result in my immediate termination from the Volunteen Program.

Print Name: _____ Date: _____

Signature: _____

# AGREEMENT AND RELEASE OF LIABILITY

In consideration of my minor child being allowed to participate in the activities and programs of Southeast Georgia Health System Volunteens and to volunteer at its facilities, I do hereby waive, release and forever discharge Southeast Georgia Health System and its directors, officers, agents, employees, representatives, successors, executors, and all other form and all responsibilities or liability for injuries or damages resulting from my child's participation in any volunteer activities. This includes occasions when my child may be transferred or transported by Health System personnel to various sites owned or operated by the Health System or its strategic affiliates. I do also hereby release all of those mentioned and any others acting upon their behalf from any responsibility of liability for any injury or damage to my child, including those caused by the negligent act or omission of any others not released under this Agreement in any way arising out of or connected with my child's participation in any activities of Southeast Georgia Health System.

Name of Minor Child: _____

Signature of parent or legal guardian: _____ Date: _____

Print Name: _____ Relationship to Minor Child: _____

Witness Signature: _____ Date: _____

Print Name: _____

SOUTHEAST GEORGIA HEALTH SYSTEM

# Authorization For Disclosure of Images / Testimonials for Commerical Marketing Purposes

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**Full Name:** _____ **Date:** _____

**Address:** _____

**Contact Telephone #:** _____ **Email:** _____

**If Patient, Date of Birth:** _____ **Date of Service:** _____

I hereby authorize Southeast Georgia Health System ("Health System"), together with its team members, agents, and contractors, to use or disclose private information or images known as Protected Health Information ("PHI") about me or my treatment as described in this Authorization for marketing purposes. I understand that any interview, photograph, movie, video or audiotape taken will become and remain the sole property of the Health System or the authorized media organization named in this Authorization.

**Information to be used or disclosed:**

☒ My visual image, such as in a photograph, movie, video, etc.
☐ A movie, video or audio clip of me receiving healthcare services.
☐ A movie, video or audio clip of me giving a statement or being interviewed about treatment.
☒ A written quotation from me regarding the treatment or services I received.
☐ Other: _____

**Person(s) or *Class of Persons* authorized to use or disclose PHI for marketing purposes:**

☒ Southeast Georgia Health System Marketing & Public Relations Department
☒ Other: Southeast Georgia Health System Volunteer Services Department

**PHI may be used by, or disclosed to or by, the following person(s) or *Class of Persons*:**

☒ To news media or print networks and the public at large via Internet, TV, radio, billboard, letter or any other marketing correspondence or forum.
☐ Other: _____

## Marketing purpose(s) regarding the use or disclosure of PHI:

I understand that my PHI will be used to encourage the use of Health System services, facilities and products by the general public and/or community, including use or disclosure for medical research, professional or patient education, audiovisuals or multimedia presentations, kiosk imaging, radio broadcasts, or any other news, public service, promotional or advertisement reason.

- The Health System will not receive direct or indirect payment in exchange for the use or disclosure of my PHI, but could indirectly benefit financially from sharing my image or statement by an increase in the use of its facilities or services or products.
- I also understand that the Health System will not pay me for the use of the information, images or videos to be used and disclosed.

## Expiration of this Authorization:

☒ This Authorization will expire on the following date or event: December 31, 2025.
☐ At the end of the marketing campaign ending: _____.

**How to cancel this Authorization**:

I understand that I may cancel this Authorization prior to its expiration to prevent the additional release of information and/or any photography, movie, video or audiotape.

- Cancellation requests must be sent, in writing, to Southeast Georgia Health System, Attention: Marketing Department, 2415 Parkwood Avenue, Brunswick, GA 31520.
- My cancellation shall not stop any use or disclosure made by the Health System prior to the date it received my written cancellation request.
- The Health System may not be able to stop an advertising campaign prior to the end of the campaign. I should not complete an Authorization for this use and disclosure of my PHI, if I am concerned that I may not wish to participate for the full marketing campaign.

**This Authorization is not a condition to my receiving treatment at the Health System*:***

I am not required to participate in marketing projects. My decision to participate or not in this marketing project will not change my full access to treatment and services at the Health System.

**Redisclosure of My PHI by Another Party**:

I understand that the information/images disclosed by the Health System for marketing purposes might be redisclosed by the recipient of my PHI, in which case it will not be protected under the HIPAA Privacy Rule or Georgia law.

- I understand that I have a right to receive a copy of this signed Authorization.
- I have read and understand this Authorization and my questions have been answered.
- I certify that I am the patient listed above or the patient's authorized representative.
- I hereby release the Health System and its officers, trustees, affiliates, employees, agents and contractors from any liability arising from the use or disclosure of Protected Health Information or images pursuant to this Authorization.

_____

Signature Print Full Name Date

**If a Patient Cannot Sign or if a Patient is a Minor Child, under age 18:**

_____

Signature Print Full Name of Authorized Patient Representative Date

_____

Relationship to Patient / Basis of Legal Authority

# SOUTHEAST GEORGIA HEALTH SYSTEM
## Application Form for Criminal Background Check (CBC)
*All requested information in Sections I and II must be legibly completed*

## SECTION I – Personal Information

**DATE:** _____

**NAME:** _____ **MAIDEN NAME**: _____

**STREET ADDRESS:** _____

**CITY:** _____ **STATE:** _____ **ZIP:** _____ **COUNTY:** _____

**DOB:** _____ **SS#:** _____ **RACE:** _____ **SEX: M F**
(Circle One)

**DRIVERS LICENSE #:** _____ **STATE ISSUED:** _____

*(List the county and state of your most recent previous places of residence and employment)*

| | **County & State** | **Length of Time (Years & Months)** |
|---|---|---|
| 1. | _____ | _____ |
| 2. | _____ | _____ |
| 3. | _____ | _____ |

## SECTION II - Authorization and Release

*I hereby give permission to Southeast Georgia Health System and its agent to verify the information submitted by me and to obtain a criminal history. Neither the Health System nor its' agent shall be violating my right to privacy in any manner and I release them from all liability whatsoever for actions related to the background investigation. I authorize release of this information to the appropriate representative(s) of Southeast Georgia Health System.*

**AFFILIATION NAME:** _____
*(Name of Hospital Department, Company, Organization, Agency, Contractor, Vendor, Service Provider, Educational Institution/Organization, other entity, etc...)*

**SIGNATURE:** _____ **DATE:** _____

## SECTION III - Safety & Security/Police Department Use Only

☐ State Criminal Check: _____ ☐ County (Name & State):_____

☐ Other Check: _____ ☐ Phone Results: _____

☐ Fax Results: _____ Results Entered in Database By: _____ Date:_____

Terminal Agency Coordinator/Operator: _____ Date: _____

☐ Note additional information on reverse side