PIEDMONT HENRY TEEN VOLUNTEER SUMMER PROGRAM APPLICATION

June 3, 2024 - July 26, 2024

Who is eligible?

- Applicants must be a rising 11th or 12th grader of June 1st and in a high school healthcare pathway, allied health program or in HOSA club.
- Applicant must be able to volunteer at least 6 out of 8 weeks during the summer break and work the required minimum 24 hours during that period. The hours can be non-consecutive but a minimum 6-week commitment.

What is required?

- Completed Application
- Two sealed letters of reference from teachers, school counselors, or coaches
- One-page narrative explaining why you want to volunteer at Piedmont Henry.
- Current immunization record or HR Empowered
- Documentation of a QuantiFERON Gold TB blood test
- Copy of insurance card
- Signed Parent/ Legal Guardian Agreement
- Attend Orientation on June 3rd at 8:30am until 2:30pm.
- $25.00 Dues which includes uniform fee. Dues will be collected at orientation on June 3rd.

All of the above requirements must be in your application package for consideration for the program except the QuantiFERON Gold TB that has to completed within 60 days of volunteer onboarding (March 1, 204 and prior to June 3, 2024). Any application package that does not have the completed application, two sealed reference letters, the one-page narrative, current immunization record, parent/legal guardian agreement will not be considered for the Piedmont Summer Teen Volunteer Program. The QuantiFERON Gold TB test documentation has to be received prior to June 3, 2024.

Applications will be accepted May 1st - May 17th

Completed application can be emailed to: PHH.VolunteerApps@piedmont.org.

*Applications can also be hand delivered to the Auxiliary Services office in the Foundation Education Building at Piedmont Henry Hospital M-F from 8:30am to 4:30pm by May 17th at 4:30pm.

Piedmont Henry Hospital
1133 Eagles Landing Parkway
Foundation Education Building, Auxiliary Services Office
Stockbridge GA 30281
Volunteer Specialist, Sherrita Emerson
678-604-1666
Piedmont Henry Teen Volunteer Summer Program Application

Name (Print): ____________________________________________  Cell Phone: __________________________

Address: ______________________________________________________________________________________

City: _______________ Zip: _______ Email: ____________________________________________________________

Gender: _____ Age: ____ Birthday: ______________________

Name of School: ________________________________________ Class of: _________________________________

Current Grade Level (circle one): 10, 11, 12  Gender (circle): Male  Female

GPA: ____ Shirt Size (circle one): SM, MED, LG, XLG, XXLG  (adult sizes only)

Will volunteering fulfill a community service or school program requirement? Yes__ No___

If yes, explain: ________________________________________________________________________________

Do you have any physical limitations requiring special accommodations in order for you to volunteer? Yes ___

No___ If Yes Explain ____________________________________________

How did you hear about the Piedmont Henry Teen Volunteer program?
______________________________________________________________________________________________

______________________________________________________________________________________________

Goals for your volunteering experience?
______________________________________________________________________________________________

______________________________________________________________________________________________

List any family members that are employed by Piedmont Henry:

______________________________________________________________________________________________

What is your career goal? ________________________________________________________________

School Activities:
______________________________________________________________________________________________

______________________________________________________________________________________________

Hobbies:
______________________________________________________________________________________________

______________________________________________________________________________________________

Are you a HOSA member? (Circle) Yes or No

List any prior work/volunteer experience:
______________________________________________________________________________________________

______________________________________________________________________________________________

Please circle any of the specific skills below that you have?

Arts & Crafts, Computer Skills (Word, Excel,), Music Skills, Graphic Design, Foreign Language, Photography,
Writing skills, or please list other skills below;
**Service Area:** Your service area will be selected based on the day of the week that you are available to volunteer. You may volunteer 1 day a week or 2 half days. You will be assigned to only one service area for both of your four hour shifts. There are a limited number of teen volunteer positions available. After the selection process is complete the teen volunteer service areas will be assigned based on a first come first serve basis. Applications will be dated and time stamped.

Please select below the days and times you are available to volunteer.

**Volunteer Shifts:** 8:00 AM – 12:00 PM, 12:30 PM – 4:30 PM,

8:00 AM -12:00PM  Monday____Tuesday ____Wednesday ____Thursday ____Friday____
12:30PM - 4:30PM  Monday ____Tuesday ____Wednesday ____Thursday ____Friday____

Which service area would you prefer? Review teen volunteer service area listing included in the application package, then complete your choices below:

1\(^{st}\) ______________________ 2\(^{nd}\) ______________________ 3\(^{rd}\) ______________________

**Parental Information and Agreement**

Name of Parent/ Legal Guardian: ______________________________________________________________

Home Address: ____________________________________________________________________________

Cell Phone: ______________________ Work Phone: _____________________

All Teen Volunteers must be covered by a family hospitalization policy which must be listed below. If it should become necessary to seek medical attention in the Emergency Department, your insurance will be utilized.

Insurance Information: Policy Holder’s Name: __________________________________________________

Policy Number ________________ Company: __________________________________________________

In case of emergency notify: ____________________________ cell phone: ____________________________

Permission is hereby granted to treat my child ______________________________ for any problem that might occur while on duty as a Teen Volunteer__________________________.

I hereby certify that the answers on this application are true and correct and that any omission of facts or misrepresentation, misleading or false information on my part will be grounded for dismissal as a volunteer. I will abide by all rules and regulations established. I understand that, if at any time, I fail to abide by the established rules and regulations, I will forfeit my privilege to serve as a volunteer and may be discharged without warning or notice.

Acceptance as a volunteer is contingent upon satisfactory references and verification of the information submitted. I authorize that all employers, schools, or references thus contacted shall be released from all liability in answering inquiries related to my application.

Student Signature_________________________________________________Date:__________

Parent / Legal Guardian Signature: ___________________________________Date:__________
### Piedmont Healthcare
**Youth/Student Volunteer Requirements**

It is mandatory for all Youth Volunteers to complete the requirements as outlined below prior to the start date at any Piedmont Healthcare facility. Suggested sources for completion of this form: Pediatrician/Primary Care Provider; Urgent Care that provides Occupational Health Services: Retail Pharmacy Clinics, Public Health Departments.

We recommend that you bring all immunization documents to your health screening.

<table>
<thead>
<tr>
<th>Volunteer Name:</th>
<th>Date of Birth:</th>
<th>Start Date:</th>
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**BELOW TO BE FILLED OUT BY Healthcare Provider**

<table>
<thead>
<tr>
<th>REQUIREMENT:</th>
<th>DOCUMENTATION:</th>
<th>COMMENTS:</th>
</tr>
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<tbody>
<tr>
<td>MMR (Measles, Mumps, Rubella). Must have one of the following:</td>
<td>MMR #1 date</td>
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<tr>
<td>• Documentation of 2 MMR vaccines OR</td>
<td>MMR #2 date</td>
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<tr>
<td>• Laboratory evidence of immunity as evidenced by positive titers</td>
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<td>Measles titer date</td>
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<td>Mumps titer:</td>
<td>Result</td>
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<tr>
<td>Rubella titer:</td>
<td>Result</td>
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| VARICELLA (Chicken Pox) | Varivax #1 date | |
| Must have one of the following: | Varivax #2 date | |
| • Documentation of 2 varivax vaccines OR | | |
| • Laboratory evidence of immunity as evidenced by positive titers | Varivax titer | Result: |

| INFLUENZA VACCINE | Flu vaccine date: | |
| Documentation of Flu vaccine for the current Flu season – applicable Sept 1st – March 31st | | Not applicable |

| TDAP | Tdap date: | |
| Documentation of Tdap Vaccine | | |
**TUBERCULOSIS**

- □ Proof of 2 step TBST with one TBST within 60 days of start date

  OR

- □ Negative IGRA testing within 60 days of start date

  □ If history of positive TBST, will be required to show documentation of treatment (if any). If had treatment, need record of CXR at time. If no treatment, need record of CXR with in past year

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<tr>
<th></th>
<th>TBST #1</th>
<th>TBST #2</th>
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<tbody>
<tr>
<td>Date Administered:</td>
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<td>Date Read:</td>
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<td>Result:</td>
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<td>Signature/title of person reading test:</td>
<td>Signature/title of person reading test:</td>
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<td>Date of IGRA Test:</td>
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<td>Result:</td>
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<td>□ Treatment record attached</td>
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<tr>
<td>□ CXR report attached</td>
<td>□ CXR report attached</td>
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* See below – Employee Health will review if any questions

Healthcare Provider Signature________________________________________________________

Print name:________________________________________________________________________

Date:________________________

Volunteer Services:

Form Received by:_________________________________________ Date:________________________

Employee Health Review (if needed)

EHS Staff signature_________________________________________ Date:________________________