ADIRONDACK HEALTH
Better Health, Better Lives

Junior "Volunteen" Program

Join us for the summer! Be part of a unique
and valuable resource for our patients and residents.

The Volunteer Services Department is looking for talented, creative, caring students to assist us in exceeding the needs of our patients and community.

Your contributions will be greatly appreciated while you learn about healthcare and a possible career path.

Contact Volunteer Services at
Adirondack Health
P.O. Box 471
2233 State Route 86
Saranac Lake, NY 12983
Tel: 518-897-2230
Fax: 518-891-1191
Email: krutledge@adirondackhealth.org
adirondackhealth.org

Junior Volunteen Program

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The Junior Volunteen Program offers high school youth ages 14-18 an opportunity to volunteer in a variety of areas throughout Adirondack Health. Volunteens provide valuable service to patients, residents, families and staff, while gaining experience and self-confidence. This popular program is a great way for teens to spend the summer.

Want to know more? Applications will be available at the Hospital Gift Shop, and your Guidance Counselor's office.

2019 Program Dates

i	**Interviews to be scheduled once all applications are received.** **Mandatory Orientation will be held one week prior to your start date.** **Summer Program runs for 8 weeks.**

Volunteen Requirements:

1. Students who are selected to participate must visit our Employee Health Nurse for required Tuberculosis screenings during a designated time in the spring. In addition, documentation is required of 2 MMR vaccines and 2 varicella vaccines or date the teen contracted Chicken Pox. A Tdap vaccine will be required if documentation of tetanus is more than 2 years old.

2. All selected Junior Volunteens **must attend a Mandatory Orientation** the first day of the 8-week program. If you are unable to attend this mandatory meeting, we will be unable to offer you a position as a Volunteen this summer.

3. Volunteens provide at least one full weekday or two ½ days each week over the course of the eight-week program.

4. We allow a maximum of 2 weeks (during the 8-week program) for vacation and summer camp. The weeks do not have to be consecutive. However, you must volunteer at least 6 weeks in order to be considered for the program. Vacation time must be submitted the first week of the program.

In appreciation of your service, Volunteens who complete the summer program and their families will be invited to a celebration in August. Certificates of Achievement and awards for cumulative hours of service will be presented.

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Volunteens must be:

Loyal

Loyalty to the organization, its administration and staff. A loyal junior Volunteen creates good will for the organization in the community.

Poised

Calm and dignified at all times, maintain composure even in moments of crisis or unusual circumstances, never permitting himself/herself to be overcome with emotion.

Respectful of Our Patients and Residents

Respecting the confidentiality of all you learn about a patient or resident while volunteering and being certain never to discuss outside of Adirondack Health. Being thoughtful and considerate of others at all times.

Willing

Sees no task as so small that it is unimportant. Serves cheerfully, efficiently and capably in any job to which assigned, never forgetting that others are depending on him or her. Meet the 3.0 grade point average requirement along with being in good standing with his or her current school.

Committed to a Quiet and Healing Environment

Volunteens do not talk loudly in hallways, in the cafeteria, or in any area while volunteering. They work hard to maintain quiet, respectful behavior at all times.

If accepted, you attend the Junior Volunteen Orientation session.
Practice the rules of etiquette listed below.

- Introduce yourself, using your first and last name when you speak to someone.
- Be a good listener.
- Always show sincere interest in patients without being too inquisitive.
- Be gracious, kind, thoughtful, understanding and very positive.

Meet the other expectations set forth in this policy as well as the policies of the organization.

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Adirondack Health Employees

Applications from children of Adirondack Health employees are reviewed in the same manner as every other student. Being the child of an Adirondack Health employee does not automatically warrant acceptance into the Junior Volunteen program.

Dress Code

Volunteens must adhere to the following requirements. The Adirondack Health Volunteer Services Office has the right to terminate a student's placement as a Junior Volunteen if he or she does not follow these requirements. These standards are set for identification and safety purposes and must be followed at all times.

Uniformed Attire

All Junior Volunteens will be given one polo shirt and are able to purchase additional Junior Volunteen polo shirts (at $19.99 each). This Volunteen shirt identifies you to employees, visitors, and patients or residents as one of our Junior Volunteens. This shirt is required to be worn during all times you are volunteering here. Shirts must be kept neat and clean.

The official Royal Blue Junior Volunteen shirt is the only shirt that may be worn while volunteering.

Blue Jeans May Not Be Worn at Any Time

Students must wear pants or skirts of a reasonable length. Please refrain from wearing shorts of any type, tank tops, halter tops, hats, short skirts, holes in pants or tops. Tight clothing should not be worn. Please cover your midriff.

ID Badges

Junior Volunteens are expected to wear their ID badge at all times while performing duties as a Junior Volunteen at Adirondack Health. Badges are to be clearly displayed at all times.

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Shoes

Flat shoes are required. Tennis shoes are permitted as long as they are well maintained and clean. No sandals or flip flops are permitted to be worn as they do not provide adequate protection. No open-toed shoes are permitted.

Hair, Makeup, Jewelry

Hair should be kept neat and clean.

Make-Up - Please keep make-up to a minimum.

Jewelry - No large hoop earrings or any jewelry that could cause possible injury to you or to a patient.

Cologne/Perfume

Perfumes and colognes should be worn of a light scent. We have many patients, residents and visitors who have allergies.

It is very important to present a neat and professional image to other volunteers, employees, patients, residents and families in the Adirondack Health community.

Lunch Break

The supervisor assigned to each Junior Volunteen determines lunch breaks and other breaks. Each Junior Volunteen will receive one 15-minute break during each 4-hour block as well as a 30-minute lunch break during any day that a student works more than 4 hours. Students will be provided a lunch ticket for the Adirondack Medical Center Cafeteria or the Mercy Living Center Cafeteria by the Volunteer Coordinator located in the gift shop.

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Department of Volunteer Services
Summer Junior Volunteen Application

Today's Date _____

_____

Last Name First Name Middle Initial

_____

Address City State Zip Code

_____

Home Telephone Cell Telephone E-mail Address

_____

School's Name Current Grade

_____

Parents/Guardian Name

Are you at least 15 years of age? Yes_____ No _____

How did you hear about the Volunteen Service Department? Friend_____ Media Ad_____
School_____ Parent_____

Are you required to volunteer? If yes, please explain: _____
_____

Have you ever been convicted (found guilty) of a crime (including probation(s) before judgment), or are there any pending criminal charges awaiting a hearing in a court of law? Do not list any criminal charges for which records have been expunged.

Yes_____ No_____

If you answered YES, please describe all convictions, when they occurred, the facts and circumstances involved, and information pertaining to rehabilitation:

_____

_____

_____

Volunteer Experience: (List most recent service positions, if any)

Position: _____ Position: _____

Agency: _____ Agency: _____

Date: _____ Date: _____

Placement Preferences: Indicate 1st (_____), 2nd (_____), and 3rd (_____) choice

1. Administrative and clerical duties
2. Gift Shop – stocking, cleaning, etc.
3. Non-Clinical: clerical, running errands, answering phones
4. Visit in-patient areas with comfort care cart
5. Nursing: assist nurses, interact with patients, and assist with meals, transport patients, learn sitter skills, greet patients in lobby, ready rooms, activities on psych units
6. Pharmacy: shelve medications, prepare and label materials, and stock rotation
7. Mercy Living Center – Tupper Lake
8. Other Interests: _____

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Department of Volunteer Services

Pre-Interview Questions

Name: _____

Date: _____

Please answer the following questions before attending your interview:

What attracted you to the Volunteen program? Is there an aspect within the program that motivates you to be a part of this program?

_____

_____

_____

_____

What would you like to get out of your volunteer experience/internship? What would make you feel like you have been successful?

_____

_____

_____

_____

Have you ever volunteered? If yes, for what agency and what position?

_____

_____

_____

_____

Describe the agency and your volunteer responsibilities.

_____

_____

_____

_____

What have you enjoyed most about your previous volunteer position(s)?

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_____

_____

_____

_____

Describe your ideal supervisor. What sort of supervisory style do you prefer to work?

_____

_____

_____

_____

What skills and qualities do you feel you have to contribute to Adirondack Health?

_____

_____

_____

_____

Are you willing to commit to the requirements of the Volunteen program?

_____

_____

_____

_____

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Student Writing Requirement

Students must write and submit a short paragraph describing "Why I want to volunteer at Adirondack Health." Please attach the paragraph to this sheet and submit it with your application.

If you are interested in having your paragraph published at the end of your service term, check the indictor box below.

☐ You have my permission to publish my essay!

Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

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Parental Consent Form

Dear Parent or Guardian:

In order for your child to apply for a Volunteen position with the Adirondack Health Junior Volunteen Program, we need your consent and involvement in helping your child have a productive experience. Please carefully read and sign this parental consent form if you would like us to continue our process of considering your child as a possible Volunteen. If you have any questions or would like further information, please call the Department of Volunteer Services at 518-897-2230.

Name of Prospective Volunteen: _____

- I understand that my child (named above) wishes to be considered for a volunteer placement and I hereby give my permission for him/her to serve in that capacity, if accepted by Adirondack Health Department of Volunteer Services.
- I understand that my child must be at least **14 years of age** to volunteer.
- I understand that my child will not receive monetary compensation for the services contributed.
- I understand that my child is required to receive, free of charge, a tuberculosis screening.
  - **If an x-ray is required, a parent/guardian must accompany him/her**.
- I understand that my child will be provided with the orientation and training necessary for the safe and responsible performance of the duties assigned. He/she will be expected to meet all the requirements of the position, including regular attendance and adherence to the Hospital and its departments' policies and procedures.
- I understand that my child will be provided emergency medical care if injured while he/she is on duty as a volunteer.
- I authorize the release of educational recommendations from my child's school to the Department of Volunteer Services at Adirondack Health.
  - I understand that the information released may be requested for review by a potential supervisor.
- I authorize the Department of Volunteer Services to publish or release to the media any pictures of my child during his/her volunteer service at Adirondack Health for promotional or recognition purposes only.

  ☐ Please check box if you **do not** consent to this statement. This box, if left unchecked, means that you do consent to any publications or media release.

  Note: The statement regarding the publishing or releasing to the media your child's photograph does not hinder the process of considering your child from becoming a Volunteen at Adirondack Health if not checked.

Parent/Guardian's Name (please print): _____

Signature: _____

Nature of Relationship to Volunteen: _____

Date: _____

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Confidential School Recommendation

Student Name: _____

Parental Consent: *I authorize the release of information from my son/daughter's school records to the Department of Volunteer Services at Adirondack Health.*

Parental Signature: _____ Date: _____

Dear Counselor or Teacher:
A student applying for volunteer service must have a recommendation from a school representative. Your evaluation and comments are appreciated. The information you provide may be reviewed by a potential supervisor. You may give the student the evaluation in a sealed envelope with your signature across the flap or you may mail it to the address listed in the top right corner of this form.

	Excellent	Good	Average	Below Average
Attendance				
Courtesy				
Dependability				
Initiative				
Scholastic Record				
Willingness				

Comments:
_____

_____

_____

_____

Name (Print): _____ School: _____

Title: _____

Signature: _____ Date: _____

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Department of Volunteer Services

References and Emergency Contact

Duration of Volunteen Services:
One Time: _____ 1-3 months: _____ More than 3 months: _____ On-call: _____

References: List two people other than relatives who would be willing to serve as personal references.

❶ _____
Name Telephone Number

_____
Street Address City State Zip Code

_____
E-mail Address

❷ _____
Name Telephone Number

_____
Street Address City State Zip Code

_____
E-mail Address

Emergency Contact: In the event of an emergency, please list the person you would want notified.

_____
Name Relationship

_____
Home Telephone Number Business Telephone Number Cell Phone Number

Statement of Understanding:
I certify that all information is true and has been given voluntarily. I understand that this information may be disclosed to any party with legal and proper interest. I release the agency from any liability whatsoever for supplying such information.

I understand that I must be at least 13 years of age to volunteer at Adirondack Health and if I am under the age of 18 years of age and/or attending high school I will need parental consent.

I understand that the Summer Junior Volunteen Program has a selection process and I am not guaranteed a placement.

Upon being offered a Volunteen position, I understand that I may be required to provide additional information pertinent to the position for which applied.

Applicant's Signature: _____ Date: _____

Parental Signature: _____ Date: _____

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Summer Junior Volunteen Student Health Record

The information requested on this form must be completed by your health care provider. Once this form has been completed, please bring it to your interview with Volunteer Services.

Name of Student: _____

Address: _____

Date of Birth: _____ Telephone: _____

OSHA CATEGORY 1: Yes_____ No_____

The following is to be completed by the Health Care Provider or college health services representative:

1. **CURRENT TB SKIN TEST (TST)** within 12 months
   If TST is positive, report of chest x-ray completed since the positive skin test.
   Date of Chest x-ray:_____ Result:_____
2. **RUBEOLA (MEASLES) TITER**
   Date:_____Result_____Interpretation_____Positive___Negative_____
   OR Date of Measles Vaccinations: #1_____ #2_____
   NOTE: As of 1/29/1989, the CDC recommends TWO doses of measles vaccine for people entering medical facilities. Vaccinations given before 12 months of age are not acceptable. Measles vaccine prior to 1968 is only acceptable if live vaccine was used.
3. **RUBELLA (GERMAN MEASLES) TITER**
   Date:_____Result_____Interpretation_____Positive____Negative_____
   OR Date of Rubella Vaccination: #1_____
4. **MUMPS TITER**
   Date:_____Result_____Interpretation_____Positive____Negative_____
   OR Dates of MMR Vaccination: #1_____ #2_____
5. **VARICELLA (CHICKENPOX) TITER**
   Date:_____Result_____Interpretation_____Positive____Negative_____
   OR Date of Varicella Vaccination: #1_____ #2_____
   *** NOTE: Having Chickenpox Does not confer immunity
   REQUIREMENT: Documentation of two (2) vaccines OR a varicella titer

PLEASE COMPLETE BELOW ONLY FOR OSHA CATEGORY 1 POSITIONS (SEE ABOVE)

6. **HEPATITIS B IMMUNITY by 3 VACCINES (provide dates)**
   #1_____ #2_____ #3_____
   OR HEPATITIS B IMMUNITY by TITER
   Date:_____Result_____Interpretation_____Positive_____Negative_____

MUST HAVE SIGNATURE OR STAMP OF HEALTH CARE PROVIDER

Name_____ Date Completed_____

Address_____ Telephone_____

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VOLUNTEEN CONSENT FORM

I am engaged in or about to be engaged in a Volunteen program at Adirondack Health. I am aware that Adirondack Health does not provide insurance coverage for volunteers if personally injured or if damage occurs to personal property while acting as a Volunteen. I further understand that I am not entitled to Workers Compensation benefits, health insurance benefits, or any other benefit available to employees of Adirondack Health. I agree that I will not hold Adirondack Health or its officers or agents thereof liable for any injury sustained to person or property while I am acting in a volunteer capacity.

In connection with my activities as a volunteen, I agree to hold all information I may have access to about patients or former patients confidential. Disclosure of such information to unauthorized persons is prohibited and will make me subject to civil action for the collection of monetary damages and/or suspension or dismissal.

I UNDERSTAND THAT IF I AM ACCEPTED AS A JUNIOR VOLUNTEEN:

I voluntarily offer my services with a clear understanding that there is no monetary compensation due to me as a benefit as a result of my services hereunder.

- I will observe all hospital regulations.
- I understand that **texting** is not allowed at any time while volunteering, as this does not create a professional impression.
- I understand that **cell phone** use is not permitted at any time while I am volunteering.
- I will endeavor to be prompt and regular in my services and I will perform my assigned volunteer duties to the best of my ability.
- I understand that program placement depends upon the needs of the hospital areas. **Students may be assigned to any area in which there is a need.**
- Photos taken while participating as an Adirondack Health Volunteen or at special functions may be used for promotional reasons (newsletters, brochures, pamphlets, etc.)
- I will adhere to Adirondack Health's dress code.
- I understand that Junior Volunteers must be under adult supervision at all times while volunteering.
- I understand that if I am sick and need to be absent from my Volunteen assignment, that my **parent** must be the one to telephone my volunteer coordinator to report that I am ill and will be absent.

I understand that the training date offered will be held one week before the start of the program and that it is mandatory.

I understand that if another commitment later arises on the training date and I am unable to attend, **that my place in the program will be offered to another student.**

Student Signature: _____ Date: _____