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:

1ST ________________________ 2nd ________________________________3rd _______________________________

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.

Volunteer Name:	Date of Birth:	Start Date:

BELOW TO BE FILLED OUT BY Healthcare Provider

REQUIREMENT:	DOCUMENTATION:	COMMENTS:
MMR (Measles, Mumps, Rubella). Must have one of the following: • Documentation of 2 MMR vaccines **OR** • Laboratory evidence of immunity as evidenced by positive titers	MMR #1 date______________ MMR #2 date______________ ______________________________________ Measles titer date________ Result:_______ Mumps titer date: ________ Result________ Rubella titer date_________ Result________	
VARICELLA (Chicken Pox) Must have one of the following: • Documentation of 2 varivax vaccines **OR** • Laboratory evidence of immunity as evidenced by positive titers	Varivax #1 date______________ Varivax #2 date______________ ______________________________________ Varivax titer date________ Result:_______	
INFLUENZA VACCINE • Documentation of Flu vaccine for the current Flu season – applicable Sept 1st – March 31st	Flu vaccine date: ______________ ☐ Not applicable	
TDAP • Documentation of Tdap Vaccine	Tdap date: _______________	

<table>
<tr><td rowspan="5">TUBERCULOSIS
□ Proof of 2 step TBST with one TBST within 60 days of start date</td><td>TBST #1</td><td>TBST #2</td></tr>
<tr><td>Date Administered:</td><td>Date Administered:</td></tr>
<tr><td>Date Read:</td><td>Date Read:</td></tr>
<tr><td>Result:</td><td>Result:</td></tr>
<tr><td>Signature/title of person reading test:</td><td>Signature/title of person reading test:</td></tr>
<tr><td>OR

□ Negative IGRA testing within 60 days of start date</td><td colspan="2">Date of Igra Test:
□ Quant Gold
□ Tspot

Result:____________________</td></tr>
<tr><td>□ 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</td><td colspan="2">□ Treatment record attached
□ CXR report attached

* See below – Employee Health will review if any questions</td></tr>
<tr><td colspan="3">Healthcare Provider Signature____

Print name:____

Date:__________________</td></tr>
<tr><td colspan="3">Volunteer Services:

Form Received by:____ Date:______________________</td></tr>
<tr><td colspan="3">Employee Health Review (if needed)

EHS Staff signature____ Date:__________________________</td></tr>
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