

Thank you for your interest in the Summer Teen Volunteer Program at USA Health Children’s & Women’s Hospital and University Hospital. Teen volunteers provide a valuable service to patients, visitors and staff while enjoying a unique opportunity for personal growth and satisfaction.

Volunteer Service Requirements

- Teen volunteers must be **16** years of age and have completed the ninth grade.
- Commit to giving 34 hours of service during the eight-week summer session (includes attending a mandatory two-hour orientation).
- Volunteer a four-hour shift weekly (same day/same time).
- Volunteers should consider other activities before making the commitment to this program. Schedule adjustments or “make-up” volunteer hours are not available.
- Volunteers who meet these service requirements will receive a certificate of service.

Application Process

- **Application deadline- March 8, 2024.** The program may reach capacity *before the deadline*; please send in completed application as soon as possible. Submitting an application does not guarantee acceptance.
- Volunteer Services only reviews **completed applications**. Incomplete applications will be sent back.

<u>Dates to remember:</u>	
March 8	Deadline to submit your volunteer application... NO EXCEPTIONS!
April 21	Orientation 4 – 6 pm
April 23	Orientation 4 – 6 pm
June 3	Program begins
July 31	Program ends & Teen Volunteer Party

If you have questions, please call the Volunteer Services Office, 251-471-7266

Sincerely,

Volunteer Services Team

I. Application Checklist

Volunteer Name: _____

- Volunteer Application (2 pages)
- Volunteer Health Assessment
- 2023 Teen Volunteer Questionnaire
- 1 Recommendation Form
- Copy of driver's license/permit, school I.D. or current photo
- Copy of current grade report showing a 2.5 GPA
- Proof of immunization (Measles, Mumps, Rubella and Chicken Pox, TDAP, Covid)
- Documentation of Tuberculosis (TB) skin test within the past 12 months

2024 Summer Teen Volunteer Orientation and Uniform Preference

Teen volunteers are **required** to attend one orientation.

Please indicate your orientation preference:

_____ **Tuesday, April 23, from 4 – 6 pm**

_____ **Thursday, April 25, from 4 – 6 pm**

Please indicate your uniform size:

T-Shirt Size: S M L XL XXL XXXL

Scrub Bottom:

Applicants accepted into the program will be responsible for purchasing their scrub bottoms. Once you are accepted into the program you will receive a letter instructing what color scrub bottoms you need to purchase

REMINDER: Indicating your orientation preference and uniform size does NOT guarantee your acceptance into the program. We will notify all applicants of their acceptance status.

**Please return your completed application to: USACWH Volunteer Services
2451 University Hospital Dr
Mobile, AL 36617**



2024 Prospective Teen Volunteers

ACKNOWLEDGEMENTS & CONFIDENTIALITY PLEDGE

The information I provided for this application is accurate and correct to the best of my knowledge. I approve USACWH to check references. USACWH is not obligated to provide a volunteer placement, nor am I obligated to accept the placement offered. Opportunities for volunteering are provided without regard to religion, creed, race, national origin, age or sex.

I recognize the necessity of maintaining the confidentiality of all data and documents collected and processed by USACWH. Confidential information is defined as proprietary business data or information which contains identifying information which can be linked to a specific individual or patient. I also recognize the importance of my part in assuring the right to privacy of persons and institutions cooperating with this facility. I further understand that this facility has both ethical and legal responsibilities to safeguard confidential information. Therefore, I will not divulge any confidential information I may encounter while volunteering at USACWH. Further, I will not make any copy of or transport off the premises any confidential information. I am aware, that in some instances, civil and criminal penalties are possible if unauthorized disclosure of confidential research records and data occurs. I agree to accept any liability which may accrue to this facility for any breaches of confidentiality which occur through my direct action.

I HEREBY AGREE THAT I WILL ABIDE BY THE POLICIES OF USACWH. I UNDERSTAND THAT IF I VIOLATE ANY OF THESE POLICIES, I MAY BE DISMISSED FROM THE VOLUNTEER PROGRAM. I HAVE CONSIDERED THE SERIOUSNESS OF THE COMMITMENT I AM MAKING AS A VOLUNTEER.

Applicant's Name: _____

Signature: _____ Date: _____

(If applicant is under 19 years of age, parent/legal guardian must sign also).

Parent/Legal Guardian's Signature: _____ Date: _____

RELEASE FROM LIABILITY

TO THE UNIVERSITY OF SOUTH ALABAMA: I, _____

understand that I will be voluntarily participating in the Volunteer Program at USACWH. In consideration of the University of South Alabama permitting me to participate in this activity, I, in full recognition and appreciation of any and all risks, hazards, or dangers, if any, inherent in this activity, to which I may be exposed, do hereby agree to assume all of the risks and responsibilities surrounding participation in such activity.

I do for myself, my heirs and personal representatives, hereby defend, hold harmless and indemnify, release and forever discharge the University of South Alabama, its trustees, officers, agents, servants and employees from and against any and all claims, demands and actions or causes of action on account of or resulting from my participation in this activity and/or which may result from causes beyond the control of, and without the fault or negligence of the University of South Alabama, its trustees, officers, agents, servants and employees, during the period of participation as aforesaid.

I fully understand the risks involved in this activity and agree to assume those risks. I understand that the University of South Alabama, its trustees, officers, agents, servants and employees assume and accept no liability for wages of any kind, personal injury or loss of life or damage to personal property.

IN WITNESS WHEREOF, I have caused this release to be signed this _____ day of _____, 20 _____.

PRINTED NAME OF VOLUNTEER

PRINTED NAME OF WITNESS

SIGNATURE OF VOLUNTEER

SIGNATURE OF WITNESS

PRINTED NAME OF PARENT/GUARDIAN

PRINTED NAME OF WITNESS

SIGNATURE OF PARENT/GUARDIAN

SIGNATURE OF WITNESS

III. Health Assessment

Part A: To be completed by the VOLUNTEER

Name: (First, MI, Last) _____

Address: _____

Are you currently under a doctor's care for any medical condition? Yes No If yes, explain:

Are you currently on any prescription medications: Yes No If yes, please list:

Today's Date ____/____/____

Date of Birth ____/____/____

Part B: To be completed by your HEALTH CARE PROVIDER(S)

Each entry MUST be initialed by your health care provider or copy of Blue Card is acceptable. All info must be in English

- MMR (Measles/Mumps/Rubella):** TWO doses are required and must be at least 28 days apart (If born before 1957 no documentation of MMR is required. If born after 1957, a self-reported 1st MMR is acceptable with a documented 2nd MMR booster).

Vaccine #1 ____/____/____ AND Vaccine #2 ____/____/____ HCP Initials _____

OR Titer ____/____/____ HCP Initials _____

- Varicella (Chicken Pox Vaccine):** TWO doses are required or declaration of history of chicken pox.

Vaccine #1 Date ____/____/____ AND Vaccine #2 Date ____/____/____ HCP Initials _____

History of Chicken Pox ____/____/____ OR Titer ____/____/____ HCP Initials _____

- Tuberculosis:** Volunteer applicants must provide written documentation of a **negative test** within the **previous 12 months**. Acceptable TB screening methods: interferon-gamma release assay (ICRA) (e.g., T-Spot, Quantiferon [QFT]), tuberculin skin test (TST).

- initial TST (read at 48-72 hours), if negative;
- a second TST (read at 48-72 hours) to confirm the first reading given 1-3 weeks from the first test

Applicants with history of positive TB screening must provide documentation of a clear chest x-ray.

Test # 1: Date Placed ____/____/____ Date Read: ____/____/____

Induration: _____ mm [] Positive [] Negative HCP Initials _____

- Tdap (Tetanus, Diphtheria and Pertussis):** One time dose of Tdap vaccine date: ____/____/____ HCP Initials _____

- COVID vaccine is no longer required, but if you have proof of vaccination, please provide a copy for our compliance documentation.**

V. Recommendation Form

This form should be completed by current school principal, guidance counselor or teacher. The person completing the form may **not** be a relative.

Volunteer Applicant's Full Name _____

Person giving the reference _____

Reference address _____

Phone _____ Relationship to applicant _____

Would you recommend this individual to volunteer at USA Children's & Women's Hospital?
 Yes No

Please describe the applicant's interpersonal relationship skills – how do they get along with people?

Rate the following qualities with A (excellent) B (satisfactory) C (needs attention)

Attitude _____ Dependability _____ Appearance _____

Is there additional information that you would like to share about the applicant?

Reference Signature _____ Date _____

Recommendation should be returned to applicant in a sealed envelope.