**Volunteer Services**
**736 Irving Avenue**
**Syracuse, New York 13210**

Dear Student,

Crouse Health sponsors a volunteer program for high school students year round.

The program is for **students who will reach their 15th birthday by June 1** of the year they intend to volunteer. We ask that volunteers at a minimum complete 4 hour shifts per week. If a letter of completion or recommendation is requested, you will be required to complete 40 hours of service prior to receipt.

Because of the popularity of the program, it has been necessary to develop a priority system.

1. The first students considered will be those who have volunteered and wish to return.
2. The second students considered are those who have relatives working at Crouse Health.
3. All others who have completed all their application requirements and have received their badge.

I look forward to hearing from you soon.

Sincerely yours,

Volunteer Services
Crouse Health

# JVP APPLICATION CHECKLIST

## PLEASE USE THE FOLLOWING CHECKLIST AS YOU COMPILE REQUIRED DOCUMENTATION FOR THE APPLICATION. DO NOT SEND IN YOUR APPLICATION UNLESS YOU HAVE CHECKED OFF ALL ITEMS AND THEY ARE IN YOUR PACKET.

**COMPLETED APPLICATION INCLUDING EMAIL ADDRESSES FOR YOUR REFERENCES. MAKE SURE YOU ASK YOUR REFERENCE FOR PERMISSION TO USE THEIR NAMES. NO RELATIVES ARE ACCEPTED AS A REFERENCE. _____**

**EXAMINATION _____ - YOU ARE REQUIRED BY OUR HEALTH OFFICE TO PROVIDE EVIDENCE OF A PHYSICAL EXAMINATION DATED WITHIN ONE YEAR.**
**_____.**

**SHOT RECORD _____ - TWO MMR'S AND TWO VARICELLA INOCULATIONS. IF YOU HAVE HAD CHICKEN POX PLEASE INDICATE HERE_____.**

**MINOR AUTHORIZATION FORM INCLUDED IN PACKET_____**

**RECENT PHOTOGRAPH – NO PRINTER COPIES PLEASE_____**

**PHOTO CONSENT FORM INCLUDED IN PACKET_____**

**YOU MAY SEND THE PACKET TO THE VOLUNTEER DEPARTMENT IN THE FOLLOWING WAYS: SCAN AND EMAIL TO volunteerservices@crouse.org; FAX care of Volunteer Department to (315) 470-5721 or MAIL COMPLETE PACKET TO:**

**VOLUNTEER SERVICES OFFICE 7WT**
**CROUSE HOSPITAL**
**736 IRVING AVENUE**
**SYRACUSE, NEW YORK 13210**

# JUNIOR VOLUNTEER PROGRAM
## APPLICATION

***PLEASE PRINT LEGIBLY* AND COMPLETE THE ENTIRE APPLICATION. NO INCOMPLETE APPLICATIONS WILL BE ACCEPTED.**

TODAY'S DATE _____ CHOICES MEMBER: YES NO YEAR_____

NAME _____ _____
Last First MI

DATE OF BIRTH _____/_____/_____ PHONE _____

ADDRESS _____
Street

_____ _____
City Zip Code

E-MAIL ADDRESS _____

PRESENT SCHOOL & GRADE _____

SHIRT SIZE: S M L XL XXL

PARENT CONTACT INFORMATION (Note this information **MUST** be fully completed by a parent or guardian. Please provide those numbers at which we could contact you in case of emergency.

_____ _____
Name (First and Last) Relationship

Best contact Phone _____ _____CELL/HOME/OFFICE

**EDUCATION**:

What is your favorite subject? _____

What extracurricular 's do you participate in? _____

What honors have you received? _____

_____

**EXPERIENCE:**

Describe any previous volunteer experience**:** _____

_____

If you have a job, where do you work? _____

What kind of work do you do and what are your hours? _____

_____

**INTEREST:**

Where would you like to work in the hospital? **(Refer to assignment descriptions and be as specific as possible)**

**A.** Patient care _____

**B.** Medical technology _____

**C.** Clerical _____

**AVAILABILITY:** Place an X in the time slots you would be available to volunteer.

| TIME | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|---|---|---|---|---|---|---|---|
| **Morning 8:00-12:00** | | | | | | | |
| **Afternoon 12:00-4:00** | | | | | | | |
| **Evening 4:00-8:00** | | | | | | | |

**ARE YOU RELATED TO ANYONE CURRENTLY AFFILIATED WITH CROUSE HOSPITAL? IF YES, PLEASE COMPLETE THE INFORMATION BELOW:**

**NAME**_____

**RELATIONSHIP**_____

**POSITION**_____

**REFERENCES:** Please list the names, relationship and **email addresses** of two references **unrelated to you**. Before sending this information, contact your potential reference to get their permission. At least one reference should be a teacher, coach, employer, etc.

**Name** _____ **Relationship** _____

**EMAIL Address** _____

**Name** _____ **Relationship** _____

**EMAIL Address** _____

**PARENT/GUARDIAN CONSENT:**

I am aware of, encourage, and support my son's/daughter's decision to volunteer in the Crouse Health Junior Volunteer Program. I understand that a decision to volunteer in this program requires a commitment of a minimum of 4 hours per shift and support the hospital and my child in his/her effort to honor the commitment. If a letter of recommendation or completion is requested you must completed 40 hours of service prior to receipt.

I also understand that all volunteers at the hospital must meet health office requirements which include submission of copies of proof of medical examination within one year of the application and a record of inoculations. In addition, all volunteers are required to undergo a tuberculosis skin test administered by our health office. Your signature indicates that we have your permission to complete the above requirements.

_____

**Printed Name** **Parent Signature**

**Date** _____

# PHOTOGRAPH/VIDEOTAPE NEWS RELEASE CONSENT FORM

**Name**_____ **Date** _____
*Print name of subject*

**Location:** CROUSE HEALTH **Time:**

**Occasion of photograph/videotaping:** During volunteer service in Crouse Health

I hereby consent that photographs or visual images taken of the above-named person may be used by Crouse Health for publication, illustration, display or other marketing/promotional purposes (including the Crouse Health website) without restriction of any kind at the sole discretion of Crouse Health.

I release and discharge Crouse Health, its legal representatives, licensees and assigns, and all parties or entities acting with its authority, from any liability arising out of or in connection with the use of these photographs or visual images.

I acknowledge that this consent and release is of perpetual duration and will remain in effect unless revoked in writing.

_____
Parent/Guardian Signature Parent/Guardian Name Printed

_____
Witness Signature Witness Name Printed

***(If subject is a minor, this consent form must be executed by a parent or guardian.)***

☐ lnternal (i.e., performance improvement or staff education
☐ External (i.e., commercial filming, television programs, marketing, news media)

# Junior Volunteer Program

## JUNIOR VOLUNTEER COMMITMENT

I, (print name) _____

I will learn that there are 6 key elements to be a good volunteer and I agree to accept them.

- Patient confidentiality is a cornerstone of good medical care. I will be especially careful not to discuss patient business outside the hospital or even in public places in the hospital where it might be overheard.

- I realize that I must learn many new procedures and hospital policies to guarantee the safety, security and confidence of patients, their family members and fellow volunteers. I will listen carefully, ask questions, follow directions and consult my mentor or the Volunteer Services leadership whenever I am unsure.

- My attendance is very important. The hospital must be able to count on me and I, in turn, will learn a great deal if I honor the schedule I have agreed to, and eagerly take on any and all tasks assigned to me. In return, I can count on my mentor to guide me, give me the support I need to do a good job, and offer me first hand understanding of health care careers.

- I understand that I must inform my area of assignment and the volunteer coordinator by mail of all absences, vacations, and change of availability or contact information as soon as possible.

- I understand that a hospital setting necessitates high standards, so I will dress and act accordingly.

- I understand that I may not leave the unit/department without first informing my mentor. I also understand that I may not leave the building without the permission of my mentor, or a volunteer services representative.

Crouse Health is very interested in providing me with a meaningful volunteer experience. At any time, I am free to discuss any matter related to my volunteer service with my mentor, Volunteer Services leadership, Supervisor of Customer Service, or Director of the Office of Patient experience.

Signature_____

Date: _____ Time: _____

Word\teens\jvp\commit