1451 El Camino Real, The Villages, FL 32159 | Phone: 352-751-8176 | Please return completed application to the hospital front desk or fax to (352) 751-8662

TEENAGE (15-17) VOLUNTEER APPLICATION FORM

This application is for Volunteer Placement Office (VPO) purposes only and is not valid until received and reviewed by the VPO. UF Health Central Florida is committed to providing a safe and healthy environment for everyone on campus. Prior to new volunteer orientation and assignment, applicants must pass all applicable background screenings.

Application Date:

Last Name (please print): **First** **Middle**

Present Address: **Street** **City** **State** **Zip**

Cell Phone: **Home Phone:**

E-mail address:

Best way to contact: ☐ Text ☐ E-mail ☐ Cell phone

Date of Birth: **Age:** ☐ **Female** ☐ **Male**

Name of Parent or Guardian who signed Permission to Volunteer form on page 4:

Cell phone:

E-mail address:

Best way to contact: ☐ Text ☐ E-mail ☐ Cell phone

Family Members working at UF Health? ☐ **Yes** ☐ **No** **Previously, but they left on ________**

EMERGENCY CONTACT

Name:____

Relationship:____

Home Phone: ____________________ **Cell Phone:** _______________________

VOLUNTEER EXPERIENCE

How did you hear about the Auxiliary volunteer program with UF Health The Villages® Hospital and UF Health Central Florida?

____

Do you have previous volunteer experience? ☐ **Yes** ☐ **No**
Where and When:

____

Please return the following documents:

1. **Completed and Signed Application**
2. **Code of Ethics for UF Health The Villages® Hospital Volunteers**
3. **Parental Permission Form Completed and Signed by Parent/Guardian**
4. **Tuberculosis Permission Form Completed and Signed by Parent/Guardian and Volunteer**
5. **New Volunteer Registration Form**
6. **Photography Consent Form Completed and Signed by Parent/Guardian and Volunteer**
7. **Additional Considerations Form Completed and Signed by Parent/Guardian and Volunteer**
8. **Two letters of Personal References**

Signature:_______________________________________ **Date:**____________________

FOR OFFICE USE ONLY

Application Received: __________ **Interview Date:** __________ **Interviewed By:** __________

Scheduled Orientation Date: __________ **Start Date:** __________

Assignment: ____

Comments:____

CODE OF ETHICS FOR UF HEALTH THE VILLAGES® HOSPITAL VOLUNTEERS

If accepted as a volunteer, I agree to:

- Abide by the Standards and Expectations as outlined in the UF Health The Villages® Hospital (hospital) Auxiliary Membership Handbook and all approved amendments.
- Hold as absolutely confidential all information that I may obtain directly or indirectly concerning patients, guests, staff, other volunteers and all matters pertaining to the hospital.
- Work without contemplation of compensation or expectation of future employment.
- Be at all times punctual, conscientious, dignified, courteous, considerate of others while demonstrating tolerance and respect for all persons.
- Wear an approved uniform in the prescribed manner and maintain a professional appearance.
- Work according to the departmental standards, assume certain responsibilities, be accountable for what I do and refer questions beyond the scope of my position to the appropriate authority.
- Recognize that I am part of a team and be willing to help develop good teamwork both within the Auxiliary and other departments throughout the hospital.
- Anticipate being assigned to a service area which meets my needs, assists with the needs of the hospital, is enjoyable to me and attend orientation and training in the services I will provide.
- Adhere to the Auxiliary procedures for signing in and obtaining a substitute when I am unable to report for duty.
- Observe all present and subsequently issued Auxiliary policies and procedures. I understand that the hospital may revise its policies and procedures at any time.
- Adhere to the policy of tobacco/smoke free campuses.
- Complete a separate application if I wish to volunteer my time with the Auxiliary organization of any UF Health hospital.

I understand that the Auxiliary reserves the right to terminate my volunteer status as a result of 1) failure to comply with policies and procedures; 2) absences without prior notification; 3) unsatisfactory attitude, work appearance; or 4) any other circumstances which, in the judgment of the Volunteer Coordinator, would make my continued service as a volunteer contrary to the best interests of the hospital and its patients.

I consent to 1) any pre-volunteer testing/screening and 2) annual health testing and training required by the hospital. I further give permission to investigate any and all information concerning my application in order to determine my qualifications. This includes but is not limited to: medical clearance, criminal background checks, employment and personal reference checks.

In the event of my resignation or termination, I agree to return the identification badge issued to me.

Signature of Applicant: ______________________________________ **Date:**_________________________________

PARENTAL PERMISSION to VOLUNTEER

I hereby agree to allow my son/daughter ____________________________ to serve as a Teen Volunteer with UF Health The Villages® Hospital (hospital) Auxiliary. I release the hospital from any responsibility or liability for any unforeseen results or causes that may arise as a result of my teenager's service. Further I hereby agree to hold harmless the hospital and the Auxiliary and agree to indemnify and defend the hospital, the Auxiliary, its officers, directors, employees and representatives from any and all liabilities and claims resulting solely from or attributable to acts or omissions of my son/daughter in the performance of these services.

1. It is mutually understood and agreed that your son/daughter is not an employee of the hospital. The sole interest and responsibility of the hospital is to ensure that the services provided by your son/daughter shall be consistent with the standards of care provided by the hospital and are consistent with the policies and procedures of the hospital and that your son/daughter performs and renders service in a competent, efficient and satisfactory provision of medical care at the hospital.

   _____ Parent's Initials

2. At the hospital's sole discretion, they may provide written notice to you that your son/daughter's work with patients or personnel is not in accordance with acceptable procedures or standards of performance or otherwise could disrupt patient services of the hospital and, therefore, your son/daughter will be removed as a volunteer.

   _____ Parent's Initials

3. Your son/daughter shall provide the following required documents or cooperate with the hospital to obtain these documents prior to start or while volunteering:

   a. Application Form
   b. Health Screening including TB skin test or chest x-ray, proof of MMR immunity or vaccination, Free of Communicable Disease Statement
   c. Agreement to comply with the Security and Privacy Policy

   _____ Parent's Initials

4. I am responsible for the transportation of my teen to/from the hospital as well as the purchase of the required uniform. (Photo ID Badge will be provided by the Hospital.)

   _____ Parent's Initials

5. I understand that my teen must commit to a minimum of 4 hours per week and must attend a Teenage Volunteer Orientation before beginning volunteer service. I also understand that volunteer service assignments may ***only*** be made by the Teen Volunteer Coordinator. My teen may ***only*** report for volunteer service as assigned. If your teen wishes to serve additional hours please consult with the Teenage Volunteer Coordinator.

   _____ Parent's Initials

6. In general, the Teenage Volunteer Program is only available during the summer months. However, teens may continue to volunteer during the school year if the assignment(s) is requested and approved by the Teenage Volunteer Coordinator following the teen's initial Volunteer service.

   _____ Parent's Initials

_______________________________ _______________________________________ ____________________

Name of *Parent/Legal Guardian* *Signature of Parent /Legal Guardian* *Date*

MINOR PARTICIPANT CONSENT, RELEASE, AND WAIVER OF LIABILITY

READ CAREFULLY BEFORE SIGNING

In consideration for my child's participation in high school student-affiliated programs at Central Florida Health, Inc. d/b/a UF Health Central Florida ("Program"), I hereby RELEASE, WAIVE, DISCHARGE AND COVENANT NOT TO SUE UF Health Central Florida and their respective employees, agents, representatives and volunteers (hereinafter referred to as "RELEASEES") from any and all liability, claims, demands, actions and causes of action whatsoever arising out of or related to any loss, damage, or injury, including death, that may be sustained by my child, or to any property belonging to my child, WHETHER CAUSED BY THE NEGLIGENCE OF THE RELEASEES or otherwise, while participating in the Program, or while in, on or upon the premises where the Program is being conducted.

Program Activities may include, but are not limited to the following:

- Onsite internship to consist of training and/or shadowing to gain experience and practical skills associated with hospital departments of interest.
  Students will experience first-hand a "day-in-the-life" of an employee within the respective department(s) of interest.

Program Activities will not include:

- Tasks which require licensure or certification.
- Contact with vulnerable patients as defined by the Agency for Health Care Administration.
- Interactions with patients where my child is left unattended or unsupervised.

I am aware that my child must comply with the following requirements:

- Strict adherence to all hospital policies and procedures.
- Absolutely no interaction with the media – any inquires of such nature must be directed to the Volunteer Supervisor who would work with the Media Relations department.
- Familiarity with UF Health Central Florida Hospital's specific guidelines regarding the use of social media and cell phone use. Photographs, video and/or digital recordings of patients are strictly prohibited, and no discussion, disclosure or posting of any patient specific information.
- Appropriate standards of behavior, including but not limited to:
  - Confidentiality/Privacy
  - Hospitality
  - Punctuality
  - Professionalism
  - Appropriate Attire

IDENTIFICATION AND ACKNOWLEDGMENT OF RISK

I am fully aware of the risks and potential hazards connected with participating in the Program, includingbut not limited to, the risk of loss of personal property from theft, risks or injuries associated with Program Activities, such as slipping and falling, risk of infection from airborne or other illnesses in a health care setting, and other injuries that may not be foreseeable, and I hereby elect to voluntarily participate in the Program, and engage in such activity knowing that the activity may be hazardous to my child and my property. I VOLUNTARILY ASSUME FULL RESPONSIBILITY FOR ANY RISKS OF LOSS, PROPERTY DAMAGE OR PERSONAL INJURY, INCLUDING DEATH, that may be sustained by my child, or any loss or damage to property owned by me, as a result of my child being engaged in the Program, WHETHER CAUSED BY THE NEGLIGENCE OF RELEASEES or otherwise.

ACKNOWLEDGEMENT OF GOOD MENTAL AND PHYSICAL CONDITION

I further acknowledge that both myself and my child are in good mental and physical condition and I do not know of any medical or physical condition, or other reason, that my child should not participate in the Program or which could interfere with my or my child's safety in such Program, or else I am willing to assume — and bear the cost of — all risks that may be created, directly or indirectly, by any such condition. My child's participation in any Program Activity is purely voluntary, and I elect to have my child participate despite the risks and known or unknown dangers associated with Program Activities.

CONSENT TO MEDICAL TREATMENT

During the Program, I hereby give permission for the Program staff to administer appropriate medical attention to my child in the event of any accident, illness, or injury, including non-prescription medications or any medications my child brings to the Program in original containers with dosage instructions that is provided to Program staff. In the event of an emergency, UF Health Central Florida medical staff may respond or 911 may be called. I will be responsible for any and all costs of medical coverage and treatment provided that is not covered by my child's insurance.

CONSENT TO PHOTOGRAPHY/RECORDING

I further authorize UF Health Central Florida to photograph, video and/or audio record my child during the Program and use or distribute any picture or video/audio recording ("Materials") related to Program Activities in which my child is depicted. I also authorize use of these Materials for publication in brochures, on UF Health Central Florida websites, and in UF Health Central Florida promotional materials. Materials may also be distributed to other Program participants, including but not limited to a Program group photograph of all participants.

SIGN-IN/SIGN-OUT OF PROGRAM ACTIVITIES

I acknowledge that for the duration of the Program, my child is responsible for signing in at the beginning of each shift and for signing out at the conclusion of each shift.

I acknowledge that the Program is not responsible for transportation for my child either to or from the Program Activity location.

My child's primary means of transportation to the Program each day will be [*check one]*: ☐ Parent/guardian ☐School bus ☐Public transportation ☐Other: _________________

My child's primary means of transportation from the Program each day will be [*check one]*:
☐Parent/guardian ☐ Walking ☐Public transportation ☐Other: _____________________________

RELEASE AND WAIVER OF LIABILITY

I HEREBY EXPRESSLY RECOGNIZE AND ASSUME ALL RISKS ASSOCIATED WITH MY CHILD'S PARTICIPATION IN THE PROGRAM AND VOLUNTARILY RELEASE, WAIVE, DISCHARGE, COVENANT NOT TO SUE AND HOLD HARMLESS THE RELEASEES. I AGREE TO INDEMNIFY AND HOLD HARMLESS the RELEASEES from any loss, liability, damage or costs, including court costs and attorneys' fees, that may incur due to my child's participation in the Program, WHETHER CAUSED BY THE NEGLIGENCE OF RELEASEES or otherwise. It is my express intent that this Participant Consent, Release and Waiver of Liability ("Waiver") shall bind the members of my family and spouse, if I am alive, and my heirs, assigns and personal representative, if I am deceased, and shall be deemed as a RELEASE, WAIVER, DISCHARGE AND COVENANT NOT TO SUE the above-named RELEASEES. I hereby further agree that this Waiver shall be construed in accordance with the laws of the State of Florida.

IN SIGNING THIS WAIVER, I ACKNOWLEDGE AND REPRESENT THAT I have read the foregoing, understand it and sign it voluntarily as my own free act and deed; no oral representations, statements, or inducement, apart from the foregoing written agreement,have been made; I am at least eighteen (18) years of age and fully competent and I am the parent or guardian of the child participant, and I execute this Waiver for full, adequate and complete consideration, fully intending to be bound by same.

Printed Participant (Minor) Name: ____

Printed Parent or Guardian Name: ____

Parent/Guardian Phone Number(s): ____

Signature of Parent or Guardian: ____

Date: ___________________________________

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Annual TB/ Latex Surveillance - Volunteers

Print Name: ______________________________DOB: __________ Date: ____________

QuantiFERON Gold is a blood test that helps in the detection of mycobacterium tuberculosis which is responsible for causing TB. This is being used as an alternative to the tuberculin skin test. The QuatntiFERON Gold is also more specific and sensitive than the tuberculin skin test.

1. Within the last year, have you developed any difficulties with latex products? ________________

   If yes, what type of problem? ____

2. Have you lived outside the United States? ☐ Yes ☐ No
3. Have you had a BCG vaccine? ☐ Yes ☐ No
4. Have you had a positive reaction to a TB Test? ☐ Yes ☐ No

   If yes, when was your last chest x-ray? ________ (if >5 years, EH nurse will order a new chest x-ray)

   Have you been to the health department? ________
   Have you been treated? ______ Where? ________ When? _____
   Do you want treatment? _______

Do you have any of the following?

	Yes	No
Chronic Cough		
Persistent Night Sweats		
Involuntary Weight Loss		
Chronic Fatigue		
Any Serious Illness		
Chest Pain		
Blood in Urine		

If you answered yes to any of the above, please explain: ________________________________

The Genetic Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting, or requiring, genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

CONSENT: I am not suffering from unexplained weight loss, loss of appetite, night sweats, fatigue, chills and fever, blood in urine, chest pain or a prolonged cough. I am not taking drugs or medication which lower my immunity, nor do I have a disease which lowers immunity. I have not had any recent vaccinations. I am not pregnant. I have read the above and consent to this test. If applicable have a chest x-ray completed.

Signature: ________________________________ **Date:** ____________

(Required for Minors)
Parent/Guardian Signature: ________________________ **Date:** ____________

Parent/Guardian Name (Print): ____

Employee Health Department Use Only

Chest x-ray ordered ☐ Yes ☐ No — Referred to Health Department □ Yes □ No

Date ordered: __________ Date completed: __________ Results: ______________

New Volunteer Registration

Name ____ Today's Date _________________
(Please print legibly)

Mailing Address:
Street Address _______________________________________
City ____
State_________________________ ZIP ________________

Home Phone Number: __________________ Cell Phone Number: ____________________

Date of Birth: _____________________

Social Security Number: _________ - ______ - _____________

Location where you will volunteer: [ ] LRMC [**X**] TVRH

Department where you will volunteer: ____Student Volunteer Program (various departments)___

Do you have an allergy to latex? [ ] Yes [ ] No

If yes, please explain: ____

Auxiliary Photography Consent Form

I hereby grant permission to UF Health Central Florida to use, copyright and/or publish photographic portraits or pictures of myself and/or minor child listed below, made through any means for art, advertising, and/or trade purposes.

By signing below I acknowledge that I have read and understand that I do not have the right to inspect or approve the finished product, the advertising copy that may be used in connection therewith, or the use to which it may be applied.

I agree not to use the UF Health Central Florida, UF Health The Villages® Hospital or any other related service line name or logo in any type of endorsement or perceived endorsement without the written permission of the Alliance Marketing & Public Relations Department.

___________________________________ Date ____________________
Print Name of Volunteer

____
Signature of Volunteer

___________________________________ Date ____________________
Print Name of Minor Child

____
Signature of Parent or Guardian

____
Witness

Additional Considerations for Parents, Guardians, and Students

Please consider the following:

We ask for a 4-hour commitment each week. Our volunteer opportunities are available in three 4-hour shifts each day, seven days each week.

To help us place you in a job that will make it easier for you to commit to the four hours per week, please circle the days and times that would fit your schedule the best.

Sunday	8 am to 12 noon	12 noon to 4 pm	4 pm to 8 pm
Monday	8 am to 12 noon	12 noon to 4 pm	4 pm to 8 pm
Tuesday	8 am to 12 noon	12 noon to 4 pm	4 pm to 8 pm
Wednesday	8 am to 12 noon	12 noon to 4 pm	4 pm to 8 pm
Thursday	8 am to 12 noon	12 noon to 4 pm	4 pm to 8 pm
Friday	8 am to 12 noon	12 noon to 4 pm	4 pm to 8 pm
Saturday	8 am to 12 noon	12 noon to 4 pm	4 pm to 8 pm

Are there other siblings or friends who will need to work on the same day and time? If so, please provide their names in the space below.

The Auxiliary will make every effort to schedule you at a time that is convenient for you. Allowances can be made for an occasional week off due to important school or family events.

Name of school ______________________________

Expectation of the number of hours this summer _______ Achieved by _____________
(date)

We agree that the days and times described above are the best for us.

_______________________________ _________________________________

Parent/Guardian signature Student signature