

## 2009 Year-round Youth Volunteer Application

### Caring Teens Volunteers Requirements:

- 15 to 18 years old
- Under 18 years, parent signature required
- Two letters of recommendation from teachers or counselors
- A copy of most recent report card, with B or above average
- A copy of applicant's school or state issued ID, or passport

NAME <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.			
(Last name)	(First)	(m.i.)	(First name for badge)
Other name (if applicable) _____		D.O.B. _____	
ADDRESS _____			
CITY _____		ZIP _____	HOME PHONE _____
Uniform size: XS, S, M, L, XL, XXL		CELL PHONE _____	
SOCIAL SECURITY# _____		E-MAIL _____	
ETHNICITY _____		GENDER _____	

### EDUCATION

High School \_\_\_\_\_ Dates \_\_\_\_\_  
Name From Until  
 Major or Field or Interest? \_\_\_\_\_

How did you hear about our program?  
 \_\_\_\_\_

Do know an employee at The Methodist Hospital? Yes No Relationship \_\_\_\_\_  
 If so, what is their name? \_\_\_\_\_

### PERSONAL DATA

Special skill, talents, hobbies, and interests: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Why would you like to volunteer? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

What other activities will you be involved in this school year? Will these interfere with volunteering here? \_\_\_\_\_

**PLEASE LIST TWO LOCAL PERSONAL REFERENCES (other than family members)**

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ZIP \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ZIP \_\_\_\_\_

Have you ever been convicted of or been on deferred adjudication for, or are you now either awaiting trial for or on deferred adjudication for, a felony or misdemeanor?  Yes  No

If yes, describe, including dates and locations: \_\_\_\_\_

Public Law 91-508 requires that we advise you that you are required to complete a criminal background check in order to process your application. If you fail to clear the background check, you may not be able to volunteer for The Methodist Hospital System. However, conviction will not necessarily bar volunteer service.

The Director of Volunteer Services will notify you if you do not meet our acceptance criteria. At that point, you will have several options for resolving issues in question. Please contact the Barbara Boucher, Director of Volunteer Services, for details, at 713.441.3351.

If accepted as a Methodist Hospital Volunteer, I agree that I

- 1) Give my permission in exchange for good and valuable consideration for The Methodist Hospital Volunteer Services to obtain information relating to my criminal history record through Volunteer Houston. The criminal history record, as received from the reporting agencies, may include arrest and conviction data as well as plea bargains and deferred adjudication. I understand that this information will be used, in part, to determine my eligibility for an employment/volunteer position with this organization. I also understand that as long as I remain an employee or volunteer here, the criminal history records check may be repeated at any time. I understand that I will have an opportunity to review the criminal history and a procedure is available for clarification, if I dispute the record as received.
- 2) Agree to the use of confidential information only as needed to perform my volunteer duties. This means I will not access confidential information without legitimate need/permission, nor in any way divulge, copy, release, sell, lend, revise, alter, or destroy any confidential information belonging to The Methodist Hospital. I understand that I will be automatically dismissed as a volunteer if I do not respect my responsibility for maintaining confidentiality.
- 3) Agree to donate my services to the hospital and to give for humanitarian, religious, or charitable reasons.
- 4) Understand that it is a crime to solicit business, other than for a charitable organization associated with my volunteer work at The Methodist Hospital. I shall not solicit any business for companies, both on or off of hospital property, or act as a runner in the solicitation business. I shall report all known occurrences of solicitation to the Director of Volunteer Services.
- 5) Shall not sell or attempt to sell goods or services, request contributions or solicit persons to sign or distribute political petitions on hospital premises, unless I receive the express authorization of the Director of Volunteer Services to engage in these activities.

6) Shall submit to health screen examinations, which may include chest X-rays, skin test, and appropriate laboratory drug screen test, as part of my volunteer services application. I also authorize the person(s) making tests or x-rays films to report the results to the volunteer office.

7) Shall be punctual and conscientious, conduct myself with dignity, courtesy and consideration of others, and endeavor to make my work professional in quality.

8) Shall attempt to resolve any problems related to my volunteer activities with my Unit Supervisor, and, if unsuccessful, attempt to resolve any such problems with the Director of Volunteer Services.

9) Shall make my best effort to fulfill my commitment to the hospital by completing all assignments that I accept.

10) Shall at all times uphold the mission of the hospital.

11) Understand that the volunteer services department reserves the right to terminate my volunteer status as a result of (a) failure to comply with hospital policies, rules and regulations; (b) 3 absences without prior notification; (c) unsatisfactory attitude, work or appearance; or (d) any other circumstances which, in the judgment of the department Director, would make my continued service as a volunteer contrary to the best interests of the patients and hospital.

<b>CONFIDENTIALITY AGREEMENT</b>	<b>YOUR NAME</b> _____
	<b>CONFIDENTIALITY AGREEMENT</b>
	I agree to use confidential information only as needed to perform my volunteer duties. This means I will not access confidential information without legitimate need/permission, nor in any way divulge, copy, release, sell, lend, revise, alter, or destroy any confidential information belonging to The Methodist Hospital. I understand that I will be automatically dismissed as a volunteer if I do not respect my responsibility for maintaining confidentiality.
	<b>Your Signature</b> _____
	<b>Social Security Number</b> _____
	<b>Today's Date</b> _____

I understand, and agree that as a condition of my acceptance in The Methodist Hospital Volunteer Program, I will be required to pass scheduled physical examinations as they relate to my ability to discharge my duties. I HAVE READ AND UNDERSTAND, AND AGREE TO THE FOREGOING PARAGRAPHS.

**Volunteer Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
**Volunteer Parent Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
(if Volunteer Under Age 18)

**IN AN EMERGENCY NOTIFY:**

NAME \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_ PHONE (work) \_\_\_\_\_ (home) \_\_\_\_\_

PHYSICIAN'S NAME \_\_\_\_\_ PHONE \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_

**ADDITIONAL COMMENTS:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Employee Health Clinic Health Screen Release Form

I agree to submit to health screen examinations, which may include chest X-rays, skin test, and appropriate laboratory drug screen test, as part of my volunteer services application. I also authorize the person(s) making tests or x-rays films to report the results to the volunteer office. I understand, and agree that as a condition of my acceptance in The Methodist Hospital Volunteer Program, I will be required to pass scheduled physical examinations as they relate to my ability to discharge my duties. I HAVE READ AND UNDERSTAND, AND AGREE TO THE FOREGOING.

Volunteer Signature \_\_\_\_\_ Date \_\_\_\_\_

Volunteer Parent Signature \_\_\_\_\_ Date \_\_\_\_\_  
(if Volunteer Under Age 18)