

Junior Volunteer Program

Information sheet

Basic Information

- The Junior Volunteer Program is for students ages 14 – 20 who are interested in a career in healthcare.
- All students planning to participate in the JV program must attend an orientation on **May 6, 2024 at 4 pm** in the dining room of NCMH.
- All students must complete application; have signed recommendation; and current immunizations. Applications due **Friday, April 12, 2024**. Late Applications will not be accepted.
- All students accepted into the program will be required to pay a \$25.00 fee to help with the cost of uniforms. Fee will be collected at orientation. Do not send any money in with application.
- There will be two 4-week sessions. Students will work 4 hours one day a week for four (4) weeks to complete program.
- The work hours are: 8:30 am – 12:30 pm or 12:30 pm – 4:30 pm.
- Session 1 will be June 3 – June 28 and Session 2 will be July 8 – August 2

What should the student hope to gain from this experience?

- ❖ Student will gain “on-the-job” training in that they will actually be working/helping a department with actual skills needed to complete job.
- ❖ Student may use completed JV Program on College and/or job Application.
- ❖ Student will be able to experience what it is like to work in hospital setting.
- ❖ Student will learn responsibility.
- ❖ Student will make new friends/mentors.
- ❖ Student will experience personal pride by helping his/her community through volunteer service.

Contact Information

Angela Bowers, Coordinator of Volunteer Services
NCMH
P O Box 497
Newberry, SC 29108
803-405-7130

angela.bowers@newberryhospital.net

CHECK PREFERRED SESSION

Session 1
June 3 – June 28



Junior Volunteer Program
2669 Kinard Street, P O Box 497
Newberry, SC 29108
803-405-7130

Session 2
July 8 – Aug 2

Newberry County Memorial Hospital Junior Volunteer Application

Name _____ email _____

Address _____
(Street)

_____ (City) _____ (State) _____ (Zip)

I hereby certify that I am 14-20 years of age Cell # _____ Text: Y N

School _____ Grade _____

I will be graduating from high school in the year _____ Date of Birth _____

Something unique about myself is _____

Have you had prior experience as a volunteer? Yes No

If so, where? _____

Why are you interested in volunteering? _____

Please share a little about yourself – (interest, attributes, career goals):

Please circle the day and shifts that you will be available for volunteer service. The morning shift is from 8:30 am – 12:30 pm. The afternoon shift is from 12:30 pm to 4:30 pm.

Monday
am pm

Tuesday
am pm

Wednesday
am pm

Thursday
am pm

I will be carpooling and would prefer the same shift as: _____

Departments I am most interested in volunteering in: _____

Departments I am least interested in volunteering in: _____

List two adult references not related to you:

Name _____ Phone _____

Address _____

Name _____ Phone _____

Address _____

By signing this application, I certify that the information I have given is true and that I am 14 years of age or older as of June 3, 2024. I am aware that by applying to be a junior volunteer, I commit to volunteering all four weeks of the program and understand that I may be dismissed as a junior volunteer if I have one (1) unexcused absence. I also understand that visiting friends/relatives will not be allowed to accompany me during my volunteer shift. As a NCMH junior volunteer, I am bound by a professional code of ethics, and agree to respect the privacy of each patient. I will not discuss a patient's presence, identity, diagnosis, or treatment with anyone either inside our outside of the hospital. 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 NCMH. I understand that I will be automatically dismissed as a junior volunteer if I do not respect my responsibility for maintaining confidentiality.

Your Signature: _____

Consent for Minor to Participate in NCMH Junior Volunteer Activities

I will authorize _____, a minor, to participate in the Junior Volunteer Program at Newberry County Memorial Hospital. I understand that daughter's/son's services are donated to NCMH without expectation of compensation or future employment.

I hereby give my permission for said minor to participate in the mandatory health screening for the NCMH Junior Volunteer Program. I understand that the screening includes a blood draw to check for TB which will be provided at no cost by the hospital. By signing this form, I also agree that my daughter/son will have reliable transportation to the facility on her/his assigned day of service.

I understand that NCMH reserves the right to terminate my daughter's/son's services as a Junior Volunteer due to any of the following: one (1) unexcused absence, a failure to comply with hospital policies and procedures, and personal conduct, attitude, or appearance unbecoming a member of NCMH Junior Volunteer Program.

I clearly understand the conditions of my daughter's/son's membership in the Junior Volunteer Program at NCMH. I release NCMH and its employees from any claim of liability for any damages, injury or illness resulting to said minor, not occasioned by any fault or neglect on the part of NCMH while participating in such volunteer activities.

I understand there is a \$25.00 fee to help defray cost of uniforms that will be due at orientation.

Parent/Guardian

Date

Where can we reach you in case of an Emergency involving your child?

Name _____ Relationship to Minor _____

Phone # (work) _____ (home) _____

If we cannot reach you, who should be contacted?

Name _____ Relationship to Minor _____

Phone # (work) _____ (home) _____

BACKGROUND INVESTIGATION AUTHORIZATION FORM

I authorize Newberry County Memorial Hospital and any of its affiliates or its designated investigative ('agency') to make whatever inquiries it may deem necessary in connection with my application for employment. As part of such inquiries, the Hospital, the affiliate, and the agency have my permission to contact persons who may have information relating to my suitability for employment and to secure consumer credit reports (including investigative consumer reports). I understand that information obtained by the Hospital, the affiliate, or the agency in accordance with this authorization may include information pertaining to my character, general reputation, personal characteristics, work habits, mode of living, driving record, judgment, liens, arrests and convictions.

I authorize NCMH and its affiliates, without reservation, to furnish copies of this authorization and my application to any person(s) and/or consumer reporting agency(ies) in connection with the above purposes.

Name (Printed) Social Security #

Other Names Used (Maiden)

Current Address City State Zip From: _____ TO: _____

Previous Address City State Zip From: _____ TO: _____

Home Telephone Number Business Telephone Number

Driver's License and State of Issue/Expiration Date of Birth

Signature of Junior Volunteer Date Witness (Parent or Guardian) Date

NOTICE ON CONSUMER REPORTS

Please take notice that the Hospital may obtain or cause to be prepared either a Consumer Credit Report or an Investigative Consumer Report on you for employment purposes. That information will be kept confidential to the extent required under the Fair Credit Reporting Act.

As an Equal Opportunity Employer, the Hospital will not use any information in any of these reports in violation of any applicable federal or local equal employment laws or regulations.

In the event that any adverse employment actions is taken with respect to you based in whole or in part on the results of the Consumer Report or Investigative Consumer Report, you will be provided a separate notice of your rights under the Fair Credit Reporting Act.

I hereby consent to the Hospital obtaining a Consumer Report or Investigative Consumer Report on me for employment purposes, and authorize the Hospital to obtain such a report(s).

Signature of Junior Volunteer Date

Witness (Parent or Guardian) Date



Release of Information/Photo/Film Release Form

I, _____, hereby authorize the release of information,
(Print name)

photographs and/or film for the use of NCMH Marketing.

I hereby agree to hold the hospital free and harmless from any and all liabilities or ill effect, which might arise from the publication of such information, photos and/or film.

Junior Volunteer Participant: _____
(Signature)

Minor's Age: _____

Minor's Parent or Guardian: _____
(Print Name)

Minor's Parent or Guardian: _____
(Signature)

Witness Signature: _____

Date: _____

Event/Situation: Junior Volunteer Program – Summer 2024

Uniform Order

Please indicate sizes: (Circle desired size of both top and bottom)

Top	-	Adult size	XS	S	M	L	XL
Bottom	-	Adult size	XS	S	M	L	XL

- ☺ Jr. Volunteers scrubs will be clean ☺ Wear clean, soft-soled tennis shoes with socks
- ☺ Name badge must be visible and worn above waist ☺ No baseball hats, do-rags, sandals, or open-toed shoes ☺ No strong perfume or cologne ☺ Minimal jewelry
- ☺ Clean hair and neat appearance is a must

- Detach the following page (Educator Recommendation) and give to an Educator to complete for you. Information for them to send to hospital is on page.

- You are now ready to submit your application.

- Please check with Educator in a week to make sure they sent their recommendation to hospital.

