The Valley Health System℠

Teen Volunteer Application

Dear Teen Volunteer Applicant,

Thank you for your interest in volunteering at The Valley Health System. You have chosen to be part of a dynamic team of volunteers who enhance the patient experience at our facilities. Please carefully review and complete all sections of the application. Teenagers who are interested in volunteering must meet the following requirements:

- Must be 16 - 18 years old and enrolled in high school *(16 by June 1st for Summerlin Hospital)*
- Have a grade point average of 2.5 or higher
- Be able to perform tasks independently with minimal supervision
- Meet minimum health requirements
- Communicate well in English
- Be willing to purchase volunteer shirt

In an effort to ensure the application review process is timely, please review the list of items needed to complete your application. All parts of the application must be turned in as one completed packet by **Feb. 28th of each year, to be considered for Summerlin Hospital's Summer Teen Volunteer Program**. Please also note that incomplete applications will not be processed. We suggest making a copy of your application for your records prior to submitting.

Teen Volunteer Applicants (ages 16-18)

_____ Application
_____ Parental Consent Form
_____ Consent to Release School Records
_____ School Guidance Counselor/Teacher Evaluation
_____ Essay - 300-500 words

Upon receipt and consideration of your completed application, you will be contacted for an interview to discuss the exciting volunteer opportunities at one of The Valley Health System hospitals. We ask for a minimum commitment of hours annually; this commitment requirement varies by hospital.

Every new volunteer is required to attend New Volunteer Orientation, an educational session covering such topics as safety, infection prevention and patient confidentiality. Volunteers are also required to have an initial and annual tuberculin skin test. If you have any questions about the volunteer application process, please feel free to contact the Office of Volunteer Services at your hospital of interest.

Thank you for your interest in volunteering.

At which hospital(s) are you interested in volunteering?

☐ **Centennial Hills Hospital** Contact: **Tara Babcock** 6900 N Durango Drive Las Vegas NV 89143 Ph:702-835-9860 Fax:702-629-1650 Email:tara.babcock@uhsinc.com www.centennialhillshospital.com	☐ **Desert Springs Hospital** Contact: **Kathleen Shelby** 2075 E Flamingo Rd Las Vegas NV 89119 Ph:702-369-7782 Fax:702-853-8571 Email:Kathleen.shelby@uhsinc.com www.desertspringshospital.com	☐ **Henderson Hospital** Contact: **Marlene Hughett** 1050 Galleria Drive Henderson NV 89011 Ph:702-963-7584 Fax:702-963-7555 Email:marlene.hughett@uhsinc.com www.hendersonhospital.com
☐ **Summerlin Hospital** Contact: **Jody Pelser** 657 Town Center Drive Las Vegas NV 89144 Ph:702-233-7532 Email:jody.pelser@uhsinc.com www.summerlinhospital.com	☐ **Spring Valley Hospital** Contact: **Therese Elliott** 5400 S Rainbow Blvd Las Vegas NV 89118 Ph:702-853-3538 Fax:702-853-3057 Email:therese.elliott@uhsinc.com www.springvalleyhospital.com	☐ **Valley Hospital** Contact: **Kathleen Shelby** 620 Shadow Lane Las Vegas NV 89106 Ph:702-388-4574 Fax:702-388-4750 www.valleyhospital.net

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IF ACCEPTED AS A HOSPITAL VOLUNTEER, I AGREE THAT:

1. I shall hold as absolutely confidential, all information I obtain directly or indirectly concerning patients, doctors or staff, and not seek to obtain confidential information.

2. My services are donated to the hospital without contemplation of compensation or future employment, and given with humanitarian, religious or charitable reasons.

3. I shall submit to an annual tuberculin skin test and any other health examination which may be necessary as part of my volunteer services.

4. As a TEEN VOLUNTEER I am between 16 years and 18 years old and currently attending high school.

5. I understand I am required to take safety and educational training yearly or as required by the hospital.

6. I shall be punctual and conscientious, conduct myself with dignity, courtesy and with consideration of others, in my endeavors as a professional volunteer.

7. I shall make my best effort to fulfill my commitment to the hospital by completing all assignments that I accept.

8. I shall at all times uphold the mission, vision, values and standards of the hospital.

9. I understand 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) absences without prior notification; (c) unsatisfactory behavior or conduct, work appearance; or (d) any other circumstances which, in the judgment of the department director, would make my continued services as a volunteer, contrary to the best interests of the hospital.

I have read each of the above conditions and I agree to be bound by them as well as all hospital policies and procedures with The Valley Health System.

_____ _____ _____ _____

Applicant Signature Date Parent Signature Date

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Office of Volunteer Services - Parental Consent Form

This consent form assures that you understand and agree to the following:

1. Your child meets the age requirement of 16 -18 years of age and enrolled in high school.
2. He/she volunteers with your approval.
3. Both you and child realize that volunteering at a hospital within The Valley Health System is a very important commitment.
4. Your child must follow all rules and regulations established by the Office of Volunteer Services and The Valley Health System, especially as it relates to attendance at volunteer orientation and maintaining patient confidentiality at all times.
5. I understand my child will have a two-step tuberculin skin test prior to volunteering and that The Valley Health System will administer this test at no cost to me. I further understand my child must have a tuberculin skin test annually in order to continue volunteering.
6. Your child must be regular in attendance and in the proper uniform.
7. Your child commits to volunteering the minimum number of volunteer hours specified by the hospital where volunteer service will be completed.

It is the policy of The Valley Health System that any minor volunteering should have a parent's consent for any emergency treatment needed while volunteering.

I hereby give permission for my child to perform volunteer services at The Valley Health System.

I realize the need for my child to be dependable, courteous and uphold the hospital code of ethics. I will be glad to cooperate with him/her in complying with the rules and regulations set up for both the volunteer's and hospital's protection.

I will not hold The Valley Health System or its hospitals responsible for any illness or injury incurred by my son/daughter, which is related to a previously existing medical condition/disability.

I understand it is my responsibility to inform the Office of Volunteer Services of any such pre-existing condition/disability prior to my child's receiving his/her assignment.

I give permission to the provided references to release information on my child as requested on the reference form by the Office of Volunteer Services at The Valley Health System.

I authorize a representative of the my child's school to complete the School Guidance Counselor/Teacher Evaluation Form in connection with my child's application to participate in the Teen Volunteer Program at The Valley Health System. I understand the purpose of the form is to aid The Valley Health System in selecting qualified Teen Volunteers.

It is my understanding that all information will be kept in strict confidence.

Printed Name (parent/guardian): _____

Signature (parent/guardian):_____ **Date:** _____

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Student Counselor/Teacher Evaluation Form

The student named below is applying for membership in the Teen Volunteer program at The Valley Health System. The following information is requested to assist in evaluating the applicant's eligibility.

Please return form to the student.

Dear Counselor/Teacher:

As Parent/Guardian I hereby give my permission for the release of this requested information.

Parent/Guardian Signature:_____ Date:_____

Student's Name:_____ School:_____

In recommending this student for volunteer service, please take into account that every volunteer assignment in a hospital setting is a serious assignment. The Teen Volunteer must be able to adjust to working in an environment where patients and their families are experiences varying levels of stress. As the volunteer moves about the hospital, he/she must be able to conduct himself/herself in a mature manner, with poise and courtesy.

School Attendance Record	☐ **Good**	☐ **Poor**
School Punctuality Record	☐ **Good**	☐ **Poor**
School Academic Record	☐ **Good**	☐ **Poor**

Characteristics	Superior	Good	Average	Poor
Leadership				
Ability to follow directions				
Ability to work independently				
Ability to work with others				
Emotional Stability				
Appearance				

I recommend this student for volunteer services	☐ Yes	☐ No	
Comments:			

Printed Name: _____ Title: _____

Signature: _____ Date: _____

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Birthdate(MM/DD/YY): _____	☐ I certify that I meet all criteria The Valley Health System requires in order to be a teen volunteer and that I am 16-18 years of age, enrolled in high school.

Applicant Contact Information

Name:_____
Last First Middle

Address:_____
Street City State Zip Code

Home Phone: _____ Cell Phone: _____

Email Address: _____

Emergency Contact Information

Parent or Guardian's Name: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Preferred Method of Contact: ☐ Home Phone ☐ Cell Phone ☐ Email

School Information

Name of School: _____ Grade: _____ GPA: _____ Graduation Year: _____

Work or Volunteer Experience

Volunteer Experience:	Name of Organization: _____ Dates of Service:_____ Position: _____
Volunteer Experience:	Name of Organization: _____ Dates of Services:_____ Position: _____
Work Experience:	Name of Employer: _____ Dates of Employment: _____ Position:_____

Personal Interests - Tell Us About Yourself

How did you hear about our Teen Volunteer Program?

Are you interested in a Medical Career? If yes, what area?

In what area(s) are you interested in Volunteering? 1. _____ 2. _____

Who encouraged you to volunteer?

Have you previously applied to the Teen Volunteer Program? If yes, when?

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Availability – Please indicated below ALL days and times you are available to volunteer							
Times	**Sunday**	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
8 am - 12 pm							
12 pm - 4 pm							
4 pm - 8 pm							

References	
1. Name: _____ Relationship: _____	Address:_____ _____ Phone: _____ Email: _____
2. Name: _____ Relationship: _____	Address:_____ _____ Phone: _____ Email: _____

The information provided is accurate and correct to the best of my knowledge. My signature indicates that I give my approval and permission for The Valley Health System to check my references. I understand I will not be compensated for my services and I understand that the Office of Volunteer Services is not obligated to provide a placement, nor am I obligated to accept the position offered. My signature indicates if an assignment is accepted, I agree to abide by all The Valley Health System rules and regulations as they will be outlined in the New Volunteer Orientation and Volunteer Handbook.

Applicant Print Name: _____

Applicant Signature: _____Date: _____

For Office Use Only

Date Application Received: _____ Application Complete: **YES** or **NO**

Interviewer _____ Date _____ Time _____

Orientation Date: _____ First Day Scheduled: _____ Supervisor Notified: _____

Assignment: _____ Day(s) _____ Time(s) _____

Comments: _____

_____

_____