JUNIOR VOLUNTEER

Dear Teen Applicant:

Thank you for applying to become a Junior Volunteer with the Parrish Medical Center. The following information is provided to help you complete your application and answer a few of the questions you may have concerning our organization.

Membership is open to all young men and women between the ages of 15 and 19, inclusive, who are enrolled in school, and interested in service to the patients and employees of Parrish Medical Center. The services provided by our Junior Volunteers include Courier/Escort, Registration and other areas as needs arise. Additional information about services will be given to you during your interview. Please keep in mind that hospital service requires volunteers to be loyal, and use tact and discretion in every encounter, whether with patients or fellow care partners (employees, volunteers and physicians).

Junior Volunteers work shifts in a 4 hours time frame. The work day is divided into three shifts: morning (8:00 a.m. to 12:00 p.m.), afternoon (12:00 p.m. to 4:00 p.m.) and evening (4:00 p.m. to 8:00 p.m).

Most of our Junior Volunteers work one shift a week, however some work every other week. Junior Volunteers are required to work a minimum of 50 hours each year.

Uniforms are required and will be explained at your interview (white/khaki pants, volunteer services teal shirt, rubber or canvas shoes).

We hope you will find—as many thousands of teenage hospital volunteers across the nation have— tremendous satisfaction from giving your time and talents to a useful purpose.

If you have any questions or concerns, please do not hesitate to contact the Volunteer Services department at 321-268-6111 extension 7183 or also by email at Volunteerservices@parrishmed.com

Junior Volunteer Service Application

Parrish Medical Center

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Number: - - Mobile Number : - -

Emergency Contact: _____
Name Phone Relationship

Email address: _____

Age: _____ Birthdate (mm/dd/yy): _____

(Must be 15 to 19 years of age and enrolled in school)

School Attending: _____ Grade: _____

Organization(s) you belong to: _____

_____

References: Please provide at least 3 (teachers and fellow volunteers are acceptable)

1. _____ Phone Number _____

Email address: _____

2. _____ Phone Number _____

Email address: _____

3. _____ Phone Number _____

Email address: _____

Previous experience (volunteer, full-time or part-time work): _____

_____

Why do you want to become a Junior Volunteer? _____

_____

_____

Additional Comments: _____

_____

JUNIOR VOLUNTEERS

Dear Parent(s):

Your son/daughter would like to serve as a volunteer at Parrish Medical Center and has requested an application for membership in the Junior Volunteer program. Parrish Medical Center would be pleased to consider him/her as a member of the Junior Volunteer program if this meets with your approval. The Junior Volunteer will wear a teal Volunteer Services logo shirts and white/khaki pants while on duty, and will work alongside Parrish Medical Center Care Partners. Some services provided by our Junior Volunteers include Courier/Escort, Registration and other services as the need arises.

If you approve of your son/daughter serving in this worthwhile program, please sign and return the consent form below. The consent form must be received by Parrish Medical Center before any action can be taken on the membership application.

If you have any questions or concerns, please do not hesitate to contact the Volunteer Services department at 321-268-6111 extension 7183 or also by email at Volunteerservices@parrishmed.com

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CONSENT FORM

To: Parrish Medical Center
Volunteer Services

My son/daughter*,___________________________________, has my (our) consent to serve as a teenage volunteer at Parrish Medical Center.

____
Signature of Parent/ Parents/ Guardian

____
Printed Name of Parent/ Parents/ Guardian

____
Contact Number

____
Address

____
City State Zip

Date _____________________

***Please be advised that we must have your son's/daughter's shot record before they may begin volunteering. Thank you.**

CODE OF ETHICS FOR VOLUNTEERS

As a volunteer, I realize that I am subject to a code of ethics that binds the employees at Parrish Medical Center and its off-site family of services. Like them, I assume certain responsibilities and expect to account for my actions based on the organization's expectations. I will keep confidential matters confidential. As a " junior volunteer" I have agreed to work with no monetary compensation. But, once accepted as a volunteer worker, I expect to do my work according to the high standards expected of paid care partners.

I believe that all work should be carefully analyzed so work methods can be standardized. I believe that people should be studied in order to determine what jobs they can do and like to do, and that as far as possible, they should be assigned to jobs they can do well and enjoy.

I promise to be open-minded in my work, to be trained for it, and bring interest and attention to it. I realize that I may have assets that my co-workers may not have andthat I should use these to enrich the projects we are working on together. I also realize I may lack assets that my co-workers have. I will not let this make me feel inadequate, but will endeavor to assist in developing good teamwork.

I will learn how I can best serve the activity for which I have volunteered, and offer as much as I am sure I can give, but no more. I realize that I must live up to my promises and, therefore, will be careful that my agreement is simple and clear so that it cannot be misunderstood.

I believe my attitude toward volunteer work should be professional. I believe that I have an obligation to my work, to those who direct it, to my colleagues, to those for which it is done, and to the public.

Being eager to contribute all I can to Parrish Medical Center's healing environment,I accept this Code of Ethics for Volunteers as my code, to be followed carefully and cheerfully.

Signed_____Date_____

Print Name _____

VOLUNTEER SERVICES
REQUEST FOR LOCAL LAW ENFORCEMENT CHECK FOR APPLICANTS

Pursuant to Chapter 85-54, Laws of Florida, Parrish Medical Center requests a local records check on the applicant listed below:

Last Name	Middle	First

Social Security Number

Date of Birth	Race	Sex

Please document the findings on this check and return the information to:

Parrish Medical Center
Human Resources
951 N. Washington Avenue
Titusville, FL 32796
Phone: 321-268-6111 ext. 7741
Fax: 321-268-6878

I hereby authorize Brevard County Sheriff's Department to check any and all records pertaining to criminal convictions, and for any law enforcement agency to release to Parrish Medical Center information regarding convictions under Florida Statutes or statutes of other jurisdictions.

Signature of Applicant	Date

CONFIDENTIALITY AND NONDISCLOSURE AGREEMENT

As an employee, regular staff or contracted, volunteer, physician, physician office personnel, student, or vendor at Parrish Medical Center, I have the duty to protect the confidentiality of all patient, medical, financial, employee, organizational, and other types of information as outlined in this agreement. I also understand that each and every patient, visitor, guarantor, employee, and other individual associating or interacting with Parrish Medical Center has the legal right to confidential treatment of information about himself or herself.

Therefore, any and all information I am exposed to in the course of performing my professional duties or that I come into contact with in the course of my interactions with Parrish Medical Center will be treated as highly confidential, and will not be disclosed to anyone who does not need that information to perform his or her professional or medical care duties. Physicians, nurses, and other patient-care personnel should never disclose patient information to anyone who is not directly involved in that patient's current care, including, but not limited to the patient's spouse, family and relatives, friends, or other physicians or caregivers who treat the patient for other reasons.

The security and confidentiality of information accessed through electronic information systems is protected through the use of personal user IDs and passwords. The following statement describes your understanding of the significance of accessing protected health information electronically and the implications of any misuse:

> I understand that personal user IDs and passwords are the equivalent of my legal signature and I am responsible for their use. I will never knowingly allow anyone to use my user IDs and passwords or leave a system unattended without signing out. I will not disclose my user IDs and passwords to anyone or attempt to gain knowledge of another person's user IDs and passwords to obtain access to any system. In the event that I have any reason to believe the confidentiality of my user IDs and passwords has been compromised, I will immediately notify Information Systems or the appropriate system administrator of the violation and have my password changed. Any misuse of my user IDs and passwords to obtain clinical, financial, or business information that is not in the direct performance of my duties or responsibilities is a violation resulting in disciplinary action up to and including termination.
>
> **Accordingly, I pledge and assure that I will protect the confidentiality of any and all patient, medical, financial, employee, organizational, and other types of information to which I am exposed. This pledge of confidentiality applies to all sources of information and methods of communication, including but not limited to computer systems, paper documents, email, telephone, direct verbal, and all other forms of communication.**

I further agree that except as permitted or required by this agreement or by law, I expressly agree to comply with the Health Information Portability and Accountability Act (HIPAA) in all respects, including the implementation of necessary safeguards to prevent such disclosure.

I have read and fully understand the above and agree to be bound by each and every term and condition of this agreement with Parrish Medical Center.

_____/_____/_____

**Print: ***First Name MI *Last Name

_____ _____

*Signature *Contact Phone Number

_____ _____

*Date Email Address

*Required Fields

VOLUNTEER SERVICES
WORKERS' COMPENSATION VERIFICATION FORM
AND
STATEWIDE CRIMINAL HISTORY BACKGROUND CHECK

RESEARCHERS ASSOCIATES, INC.
850-893-2548 / 850-893-9518

Applicant's Name _____

Social Security Number _____

Date of Birth _____

Has this person had a workers' compensation claim filed in the state of Florida in the last _____years? □ Yes □ No

If Yes, Employer _____

Date_____

Type of Injury _____

Time Lost _____

Person Providing Information _____

Today's Date _____

Consent to Photograph, Videotape, Film or Interview

Parrish Medical Center (PMC) is committed to protecting the privacy and confidentiality of our patients/community and their information.

I,_____,
(Please print: patient or his/her legal representative name)
hereby authorize and grant permission to PMC, and/or its representatives to:

☐ To photograph/videotape//film me (or my minor child) to document the progress of my medical care.

☐ To release pertinent medical and other information to the media about me (or my minor child's name) beyond the one word condition description (Good, Fair, Poor, Critical, Serious, or Undetermined).

☐ To interview me (or my minor child's name) for use by the news media: newspapers, magazines, radio, television, etc.

☐ To interview me (or my minor child's name) for use within PMC's marketing or publicity materials.

☐ To photograph/videotape/film me (or my minor child) for use in marketing or publicity materials.

In signing this agreement, I understand that:

1. Editing of these materials by individual media (*i.e.* television, newspaper, magazine) representatives will be done so at their discretion, and that this discretion is beyond PMC's control.
2. I have agreed to participate without monetary compensation.
3. I can revoke my consent at any time in writing, but if I do, it will not have any effect on any actions taken prior to my revocation.
4. I may refuse authorization and that this is strictly voluntary.

_____ _____
(Signature) (Date)

_____

(Witness)

Phone Number: _____

Mailing Address: _____

Email Address: _____