For Office Use Only
Volunteer #: ______

LEE MEMORIAL HEALTH SYSTEM

VOLUNTEER RESOURCES

APPLICATION FOR TEENAGE VOLUNTEERS

Cape Coral Hospital	HealthPark Medical Center	Lee Memorial Hospital	Gulf Coast Medical Center
636 Del Prado Boulevard	9981 S. HealthPark Drive	2776 Cleveland Avenue	13681 Doctor's Way
Cape Coral, Florida 33990	Fort Myers, Florida 33908	Fort Myers, Florida 33901	Fort Myers, Florida 33912
Telephone: 239-424-2206	Telephone: 239-343-5055	Telephone: 239-343-2388	Telephone: 239-343-0636
Fax: 239-424-4016	Fax: 239-343-5403	Fax: 239-343-2512	Fax: 239-343-0996

Date: ______

PLEASE READ CAREFULLY, PRINT CLEARLY, AND ANSWER ALL QUESTIONS. THANK YOU!

At which **LEE MEMORIAL HEALTH SYSTEM** location do you prefer to volunteer?

- ❑ Cape Coral Hospital
- ❑ Gulf Coast Medical Center
- ❑ HealthPark Medical Center
- ❑ Lee Memorial Hospital
- ❑ CCH Child Development Center
- ❑ HPMC Child Development Center
- ❑ LMH Child Development Center
- ❑ HealthPark Care & Rehabilitation Center

PLEASE PRINT

Name: ______ (LAST) ______ (FIRST) ______ (MI)

Preferred Name for ID Badge (if different from above): ______

Street Address: ______

City: ______ State: ______ Zip: ______

Home Phone: (____) ______ Cell Phone: (____) ______ EMail: ______

Sex: ❑ Male ❑ Female Birthdate: _____-_____-_____ (M D Y)

IN CASE OF EMERGENCY, NOTIFY:

Parent/Legal Guardian: ______ Relationship: ______

Street Address: ______

City: ______ State: ______ Zip: ______

Home Phone: (_____) ______ Business Phone: (_____) ______ Cell Phone: (_____) ______

Physician's Name: ______ Phone (_____) ______

WORK PREFERENCES:

WORK TIMES: ❑ Morning *(ex. 8:00 AM-12:00 PM)* ❑ Afternoon *(ex. 12:00-4:00 PM)* ❑ Evening *(ex. 4:00-8:00 PM)*

WORK DAYS: ❑ Monday ❑ Tuesday ❑ Wednesday ❑ Thursday ❑ Friday ❑ Saturday ❑ Sunday ❑ Any Day *(flexible)*

WORK AREA PREFERENCE: ______

REASON FOR JOINING VOLUNTEER PROGRAM? ______

______

EDUCATION INFORMATION

SCHOOL ATTENDING: ______________________________ GRADE LEVEL: ____________

GUIDANCE COUNSELOR: ______________________________ PHONE: ______________

Are you volunteering to receive academic credit? . . . . ❑ Yes ❑ No

If YES, please contact your Guidance Counselor for the appropriate paperwork.

OF VOLUNTEER HOURS NEEDED: __________ EXPECTED HIGH SCHOOL GRADUATION DATE: _____-_____-_____

Have you ever applied for the LMHS Teenage Volunteer Program prior to this application? . . . . ❑ Yes ❑ No

Did a current LMHS volunteer recruit you? . . . ❑ Yes ❑ No If YES, who?______________________

BACKGROUND INFORMATION

Have you ever been convicted of, had adjudication withheld, or pled guilty or nolo contendre (no contest) to a criminal offense (misdemeanor or felony)? *(We do criminal checks. Falsification or failure to disclose this or any other information on this application is grounds for termination. A conviction does not necessarily disqualify you from volunteer service.)* . . . . ❑ Yes ❑ No

If YES, please explain: ____

Have you ever been refused bond? . . . . ❑ Yes ❑ No

If YES, please explain: ____

Have you previously been an employee/volunteer for the Lee Memorial Health System? . . . . ❑ Yes ❑ No

If YES, provide dates of employment/volunteer service, location and name of supervisor: ____________________

SKILLS, ACTIVITIES AND WORK EXPERIENCE:

Special Skills and Talents: ____

____

School Activities and Awards: ____

____

Community Affiliations: ____

____

Volunteer Experience: ____

____

Work Experience / Skills:____

____

Languages:____

____

Other:____

____

TEENAGE VOLUNTEER APPLICATION

Medical History and Authorization

LEE MEMORIAL
HEALTH SYSTEM

As a potential Lee Memorial Health System volunteer you may be required to complete a 1-step Tuberculosis (TB) skin test prior to being placed into a volunteer position. If you have had a positive reaction to a TB skin test, you will be screened by our Employee Health nurse and given instructions if a follow up is necessary. The hospital will provide the TB skin test free of charge at Cape Coral Hospital, Lee Memorial Hospital, HealthPark Medical Center or Gulf Coast Medical Center during regularly schedule clinic hours. Lee Memorial Health System requires that you take a TB skin test annually.

VOLUNTEER NAME: ______________________________ AGE: __________

MEDICAL HISTORY

List Any Restrictions Of Applicant: ______________________________

Last Tetanus/Toxoid Booster: ______________________________

Allergies to Drugs/Food: ______________________________

Pertinent Medical History and any Special Medications Taken: ______________________________

TO PARENT:

If your child has epilepsy, diabetes, allergies, heart condition, etc., and/or is taking special medication for any condition, it is important that you advise us so that in the event of an emergency resulting from his/her illness, medical personnel can provide proper treatment. This information will at all times remain confidential, except where it affects his/her ability to receive medical attention.

List any Physical Limitations of Child: ______________________________

INSURANCE COMPANY: ______________________________ POLICY #: __________

POLICY HOLDER'S NAME: ______________________________

PARENT/GUARDIAN SSN #: ______________________________

EMPLOYER: ______________________________ PHONE: (_______) __________

ADDRESS of EMPLOYER: ______________________________

AUTHORIZATION

I, we, the undersigned, parent(s)/legal guardian of ______________________________, a minor, do hereby authorize Employee Health Nurse or Designee as agents for the undersigned to consent to any LMHS (1) pre-volunteer testing required; (2) x-ray examination; (3) anesthetic; (4) medical or surgical diagnosis or treatment and hospital care which is deemed advisably by, and is to be rendered under the general or special supervision of any physician licensed under the provisions of the Medicine Practice Act on the medical staff of the above named health system, when such diagnosis or treatment is rendered at said health system.

It is understood that this authorization is given in advance of any specific diagnosis or hospital care being required and is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment of hospital care which the aforementioned physicians, in the exercise of his best judgment, may deem advisable.

It is understood that the effort shall be made to contact the undersigned prior to rendering treatment to the patient, and that any of the above treatment will not be withheld if the undersigned cannot be reached.

AUTHORIZATION SHALL REMAIN IN EFFECT UNTIL: ______________________________

SIGNATURE OF PARENT/LEGAL GUARDIAN: ______________________________ DATE/TIME: __________

PLEASE READ AND SIGN:

IF ACCEPTED INTO THE LEE MEMORIAL HEALTH SYSTEM VOLUNTEER PROGRAM, I AGREE TO:

- ❑ Hold as absolutely confidential all information that I may obtain directly or indirectly concerning patients and staff.
- ❑ Become familiar with LMHS' policies and procedures and uphold the Code of Excellence.
- ❑ Donate my services without contemplation of compensation or future employment.
- ❑ Be professional, conscientious and conduct myself with dignity, courtesy and consideration of others.
- ❑ Furnish the appropriate volunteer uniform and maintain a well-groomed appearance.
- ❑ Attend orientation and inservice training as scheduled.
- ❑ Carry out assignments and seek the assistance of my supervisor when necessary.
- ❑ Take any problems, criticism or suggestions to my service area supervisor.
- ❑ Work a specified number of hours on a schedule acceptable to LMHS.
- ❑ Adhere to the volunteer department's sign-in procedure.
- ❑ Be punctual and notify my supervisor if unable to work as scheduled and find a substitute according to the volunteer substitution policy.
- ❑ Honor the minimum commitment of volunteer service with the first 16-20 hours being a probationary period.
- ❑ I understand that the **Volunteer Resources Department** reserves the right to terminate my volunteer status as a result of (a) failure to comply with health system policies; (b) 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 continued services as a volunteer contrary to the best interests of Lee Memorial Health System and its patients.
- ❑ I, the undersigned, consent to any (1) pre-volunteer testing/screening required by the hospital; (2) annual health testing required by Lee Memorial Health System.

I hereby certify that there are no misrepresentations concerning my personal and professional history. I am aware that mis-statements of material facts may cause me to be disqualified from holding a volunteer position in the Lee Memorial Health System. I have read each of the above conditions and agree to honor them.

Signature of Volunteer: ________________________________ Date/Time: ______________

I give my permission for my son/daughter to become a member of the LMHS Teenage Volunteer Program.

Signature of Parent/Legal Guardian: ________________________ Date/Time: ______________

(if volunteer is under 18 years of age)