Volunteer Services
Colquitt Regional Medical Center
P.O. Box 40 * Moultrie, GA 31776
(229) 891-9181

Dear Prospective **Youth Volunteer (YoVo),**

Thank you for your interest in Colquitt Regional Medical Center's Youth Volunteer Program. Below you will find detailed information and requirements for our program.

Minimum Qualifications for Participating in the program:

- Must be at least 14 years of age, entering into the 9th grade as a full-time student to 18 years of age as a full-time senior student.
- Have a GPA of 3.0 or higher. ("B" average)
- Provide a reference from a current teacher or school guidance counselor using the enclosed form.
- A mature individual with a potential interest in pursuing a career in healthcare.
- Be COVID vaccinated or file for an exemption.

Application Procedures:

- ☐ Application: Complete the enclosed *application, a* ***$15 application fee****, background check form, and consent for protected health information.*
- ☐ Take to school: *permission for release form* signed by a parent/guardian and student AND *reference form* (and envelope) to be completed by a teacher or counselor. Teacher/Counselor recommendations should be sealed.
- ☐ Return the above applications, forms, and teacher/counselor reference to :
  - Volunteer Services Office, located on the 1st floor of the hospital, or mail to: **Volunteer Services @ CRMC, P.O. Box 40, Moultrie GA 31776**
- ☐ We will review your information; if you meet our requirements then we will contact you about attending a group interview meeting which is held monthly. At this meeting, we will discuss expectations and benefits along with a touring the hospital. (Parents are welcome to attend but it's not required)

If accepted into this program, you will then be required to:

- Clear a criminal background check. (please sign the form enclosed)
- Have a health physical, including a COVID test, drug test, and TB skin test by Colquitt Regional Medical Center's Employee Health nurse.
  - You must bring a copy of your last immunization records and your parent MUST attend this with you when scheduled.
- Attend hospital orientation and take a quiz regarding hospital safety and quality measures.
- Be available to work a minimum of one shift (4-5 hours each) per week. Note, some shifts may only be available on weekends and evenings, for example from 4 pm – 9 pm.
- Attend a bi-monthly YoVo meetings.

Note: Please understand the number of students accepted to participate depends on the number of available service positions.

Sincerely,
Nicole Gilbert
Volunteer Services Director

VOLUNTEER CHECKLIST

- ☐ **Application (2 sheets)**
  - → *Be sure you and your parent/guardian have signed the form.*
  - → *$15 Application Fee*
- ☐ **Sealed envelope from teacher or counselor that contains:**
  - → *Permission for release of confidential information form*
  - → *Reference form*
- ☐ **Criminal Background Form (2 sheets)**
  - → *Signed by youth*
- ☐ **Consent for health screening and protected health information (2 sheets)**
  - → *Be sure you and your parent / guardian have signed the form.*
- ☐ **Immunization Records. Please contact your physician for a copy. When you are accepted as a youth volunteer and scheduled to meet with our Employee Health Nurse, you will need to bring a copy of your latest immunization record and a parent MUST attend.**

Return the above items to our Volunteer Services Office, located in the Marketing / Foundation Suite on the first floor of the hospital.

You may mail to:

Colquitt Regional Medical Center

Volunteer Services

P.O. Box 40

Moultrie, GA 31776

We are looking forward to meet you!

Why YoVo?
There are many benefits to participating in Colquitt Regional Medical Center's Youth Volunteer Program. Listed below you will find just a few …..

- Free meal in the cafeteria during your shift.
- Community service looks GREAT on a college application.
- Letters of reference from hospital CEO based on your performance.
- College scholarships.
- Real work experience in the department of your choice.
- Learn communication and leadership skills.
- Make a great connection in your local community.
- Recognition at Senior Honors Night at CCHS.
- Other gifts & surprises throughout the year at our monthly YoVo meetings.

Hours Volunteered + 3.0 GPA = Scholarship!
There are four levels at which you will be rewarded for your service based on the hours you volunteer here at Colquitt Regional. With a 3.0 GPA at the end of your Senior Year, you will be honored at Colquitt County High School's Senior Honor's Night your graduating year. So, you have until you graduate to accumulate your hours!

Platinum Volunteer	**750 hours**	**$1,500 Scholarship**
Gold Volunteer	**500 hours**	**$1,000 Scholarship**
Silver Volunteer	**250 hours**	**$500 Scholarship**
Bronze Volunteer	**125 hours**	**$250 Scholarship**

If you have any questions or need more information, please contact me at (229)-891-9181. I am looking forward to meeting you.

Sincerely,

Nicole Gilbert
Foundation Director/Volunteer Director
Colquitt Regional Medical Center

Colquitt Regional Medical Center
Youth Volunteer "YoVo" Application

[print]
NAME_____
LAST **FIRST**

ADDRESS_____**CITY**_____ **ZIP** _____

(____)_____ (____)_____
Home Phone **Cell Phone**

Email: _____ **SS#** _____

Birthday_____/_____/_____ **CIRCLE** Shirt Size S, M, L, XL & Pant Size S, M, L, XL

School _____ **Grade** _____ **Year Graduating:** _____

SPECIAL INTERESTS, HOBBIES, SKILLS OR SPECIAL TRAINING:

(i.e., COMPUTER SKILLS, CASH REGISTER, ETC._____

_____

_____

SCHOOL & COMMUNITY ORGANIZATIONS:_____

_____

_____

DATES UNABLE TO VOLUNTEER:_____

_____

IN CASE OF EMERGENCY NOTIFY:

_____ _____
Parent or Guardian **Relationship**

Home # (____) _____
Work# (____) _____
Cell # (____) _____

PLEASE WRITE A PARAGRAPH ABOUT YOURSELF AND WHY YOU THINK YOU WOULD BE A GOOD VOLUNTEER.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

SIGNED BY YOUTH:

If accepted into the Youth Program at Colquitt Regional Medical Center, I understand the importance of giving courteous care and friendly aid to patients, hospital staff and visitors. I will accept assignments cheerfully and willingly, will be prompt for duty and will ask another youth volunteer to work in my place when it is necessary for me to be absent. I understand that three unreported and unexcused absences will be considered as an indication of my lack of interest, and that I will be dropped from the program.

Signature_____Date_____

SIGNED BY PARENT or GUARDIAN:

My child, _____, has my consent to serve as a youth volunteer at Colquitt Regional Medical Center and I will support the above stated responsibilities if accepted.

Signature_____Date_____

Complete this form and give to your teacher / counselor along with the *Reference Form* *and an envelope*.

Permission for Release of Confidential Information Form

I give permission for the release of any information and/or records pertaining to my grade point average (GPA) and conduct record from the school listed below:

_____

SCHOOL

_____

SIGNATURE OF STUDENT

_____

SIGNATURE OF PARENT OR GUARDIAN

Colquitt Regional Medical Center
Youth Volunteer Program
Reference Form

_____ **has applied to be a youth volunteer at Colquitt Regional Medical Center. Please complete the reference form below and the additional comments section. The "Permission for Release of Confidential Information", signed by the applicant and a parent or guardian, is attached.**

****

1. **Overall Scholastic Grade Point Average**_____

2. **Is student's overall conduct satisfactory?** _____

3. **How long have you known the applicant?** _____

4. **Please check the rating which best represents your impression of the applicant:**

	Excellent	Good	Satisfactory	Poor
Personality	( )	( )	( )	( )
Dependability	( )	( )	( )	( )
Maturity	( )	( )	( )	( )
Assumes Responsibility	( )	( )	( )	( )
Works Well With Others	( )	( )	( )	( )
Respects Authority	( )	( )	( )	( )
Follows Directions	( )	( )	( )	( )

5. **Additional comments** _____

_____

_____

_____

_____

Signature of Teacher or Counselor **Date**

PLEASE USE ATTACHED ENVELOPE AND INITIAL ON THE SEALED FLAP. RETURN TO STUDENT.

COLQUITT REGIONAL
MEDICAL CENTER

Criminal Background Authorization

I, the undersigned, hereby authorize Colquitt Regional Medical Center to receive any criminal history record information pertaining to me which may be in the files of any state or local criminal junction agency.

Please read and acknowledge by initialing items below.

_____ **Failure to list all information on criminal charges, pending charges, and/or convictions will result in the employment offer being withdrawn or separation from employment.**

_____ **Pleas of *nolo contendere* or nolle processed must be listed.**

_____ **Charges processed under Georgia's First Offender Act are not required to be listed IF all requirements have been met. (e.g. fines paid, community service, probation, etc. have been completed).**

_____ **If unsure of the status, please discuss with the hiring official or Human Resource/Personnel Office *prior* to signing this form.**

_____ **NOTE: DUI's cannot be processed under Georgia's First Offender Act, and all DUI convictions, *nolo* pleas or pending charges must be listed.**

As stated on my application for employment, I am stating one of the following.

_____I have been convicted of a violation of any federal, state, county, or municipal law, other than minor traffic violations. Please list below:

_____

_____

_____

_____ I have not been convicted of a violation of any federal, state, county, or municipal law, other than minor traffic violations.

Also, Please check one:

_____I have never been shown by credible evidence (e.g. court of jury, a department investigation, or other reliable evidence) to have abused, neglected, or sexually assaulted, or exploited, or deprived any person or to have subjected any person to serious injury as a result of intentional or grossly negligent misconduct as evidenced by an oral written statement to this effect obtained at the time of my application.

_____I have been shown by credible evidence (e.g. court of jury, a department investigation, or other reliable evidence) to have abused, neglected, or sexually assaulted, or exploited, or deprived any person or to have subjected any person to serious injury as a result of intentional or grossly negligent misconduct as evidenced by an oral written statement to this effect obtained at the time of my application.

_____ _____

Applicant Signature Date

MBI

DISCLOSURE REGARDING "INVESTIGATIVE CONSUMER REPORT" BACKGROUND INVESTIGATION

Colquitt Regional Medical Center, to which you have applied for employment, may request an investigative consumer report about you from a third party consumer reporting agency, in connection with your employment or application for employment (including independent contractor or volunteer assignments, as applicable). An "investigative consumer report" is a background report that includes information from personal interviews (except in California, where that term includes background reports with or without information obtained from personal interviews). The most common form of an investigative consumer report in connection with your employment is a reference check through personal interviews with sources such as your former employers and associates, and other information sources. The investigative consumer report may contain information concerning your character, general reputation, personal characteristics, mode of living, or credit standing. You may request more information about the nature and scope of an investigative consumer report, if any, by contacting the Company.

You have the right, upon written request made within a reasonable time, to request (1) whether an investigative consumer report has been obtained about you, (2) disclosure of the nature and scope of any investigative consumer report and (3) a copy of your report. These reports will be conducted by **MBI Worldwide, 101 N. Park Ave., Suite 200, Herrin, IL 62948; Toll-free: 866-275-4624;** www.mbiworldwide.com. The scope of this disclosure is all-encompassing, however, allowing the Company to obtain from any outside organization all manner of investigative consumer reports throughout the course of your employment to the extent permitted by law.

Signature: _____ Date: _____

MBI

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

Colquitt Regional Medical Center may obtain information about you from a third-party consumer reporting agency for employment purposes. Thus, you may be the subject of a "consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living. These reports may contain information regarding your credit history, criminal history, social security verification, motor vehicle records ("driving records"), verification of your education or employment history, drug screenings or other background checks. Credit history will only be requested where such information is substantially related to the duties and responsibilities of the position for which you are applying.

You have the right, upon written request made within a reasonable time, to request whether a consumer report has been run about you and to request a copy of your report. These searches will be conducted by **MBI Worldwide, 101 N. Park Ave., Suite 200, Herrin, IL, 62948; Toll-free 866-275-4624; www.mbiworldwide.com.** The scope of this disclosure is all-encompassing, however, allowing the Company to obtain from any outside organization all manner of consumer reports throughout the course of your employment to the extent permitted by law.

Signature: _____ Date:_____

MBI

ACKNOWLEDGMENT AND AUTHORIZATION FOR BACKGROUND CHECK

I acknowledge receipt of the separate document entitled DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by **Colquitt Regional Medical Center** at any time after receipt of this authorization and throughout my employment, if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by **MBI Worldwide, 101 N. Park Ave., Suite 200, Herrin, IL 62948; Toll-free 866-275-4624; www.mbiworldwide.com** and/or **Colquitt Regional Medical Center**. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

New York applicants only: Upon request, you will be informed whether or not a consumer report was requested by the Company, and if such report was requested, informed of the name and address of the consumer reporting agency that furnished the report. You have the right to inspect and receive a copy of any investigative consumer report requested by the Company by contacting the consumer reporting agency identified above directly. By signing below, you acknowledge receipt of Article 23-A of the New York Correction Law **New York City applicants only:** You acknowledge and authorize the **Colquitt Regional Medical Center** to provide any notices required by federal, state or local law to you at the address(es) and/or email address(es) you provided to the Company.
Washington State applicants only: You also have the right to request from the consumer reporting agency a written summary of your rights and remedies under the Washington Fair Credit Reporting Act.
Minnesota and Oklahoma applicants only: Please check this box if you would like to receive a copy of a consumer report if one is obtained by the Company. ☐

Signature: _____ Date: _____

MBI

BACKGROUND INFORMATION

Please print/type the requested information. ***Lack of legible or missing information may delay processing of this request.***

Applicant Name: _____
Last First Middle

Other legal names known by (limit to 7years): _____

Present Address: _____
Street City State Zip County

Date of Birth*: _____/_____/_____ Driver's License # _____ State _____
(MM/DD/YYYY)

SS#*: _____ Male / Female (Circle One) Race _____

Home Addresses for the Past 7 Years: (List additional addresses on separate page, if needed.)

Street Address	City	State/Zip	County	Dates Mo/Year

Applicant Phone Number: _____
(Area Code) + Telephone Number

Applicant Email Address: _____
Please Print Clearly

*This information will be used for background screening purposes only and will not be used as hiring criteria.

Name-Based Criminal History Record Information Consent/Inquiry Form

I hereby authorize MBI Worldwide to conduct a Criminal History Background inquiry for the purpose listed below and receive any Georgia and/or national criminal history record information as authorized by state and federal law.

** ALL FIELDS ARE REQUIRED

FULL NAME (PRINT) MUST BE CURRENT FULL LEGAL NAME AS IT APPEARS ON GOVERNMENT ID		
LAST	FIRST	MIDDLE

ADDRESS	
STREET	
CITY, STATE ZIP	

SEX	RACE	DATE OF BIRTH	SOCIAL SECURITY NUMBER
☐ MALE ☐ FEMALE ☐ UNKNOWN	☐ WHITE ☐ BLACK ☐ ASIAN ☐ HISPANIC ☐ UNKNOWN		☐ I HAVE NEVER BEEN ISSUED A SOCIAL SECURITY NUMBER

CHECK ONE BOX

☒ This authorization is valid for 90 days from the date of signature.

☐ I give consent to the above-named entity to perform periodic criminal history background checks or the duration of my employment.

Signature _____ Date _____

Purpose Code Used: (check one)

NON-CRIMINAL JUSTICE PURPOSES	
☐	E – Employment / Volunteer Work / Tenancy
☐	M - Working with Mentally Disabled PROVIDING 24/7 CARE – NOT for Volunteer work
☐	N - Working with Elderly – NOT for Volunteer work
☐	W - Working with Children NOT A VOLUNTEER – NOT for Volunteer work

☐ ORI STAMP REQUESTED

[PARENTAL CONSENT FOR HEALTH SCREENING OF MINORS]

Colquitt Regional Medical Center
EMPLOYEE HEALTH SERVICES

To insure the health and safety of our volunteers, Colquitt Regional Medical Center's infection control committee requires that all volunteers participate in a free health screening. This screening consists of the completion of a health history form, drug screening, a copy of the minor child's immunizations record and a tuberculosis skin test.

I, as parent or legal guardian of said minor child, and acting on his or her behalf, hereby release and discharge Colquitt Regional Medical Center and Employee Health Services from any and all claims of injury or liabilities of any administration, test processing, screening or any act or omission arising there from or related thereto. I understand the possible adverse reactions and consent for said child to have a health screen and tuberculosis test. I further understand that if the tuberculosis skin test is found to be positive, this information will be forwarded to Colquitt County Health Department and it is my sole responsibility to arrange for additional medical evaluation and treatment for these findings.

As legal guardian I give consent to Colquitt Regional Medical Center to perform medical treatment of my child if required while performing volunteer duties within the hospital. In the event of a medical emergency, I permit the attending physician in the emergency Center of Colquitt Regional Medical Center to treat my child if required while performing volunteer duties within the hospital.

Name of Child _____ SS#_____

Parent/Guardian (print name) _____

Parent/Guardian (signature) _____

COLQUITT REGIONAL MEDICAL CENTER
CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PAYMENT, TREATMENT AND HEALTH CARE OPERATIONS

By signing below, you hereby consent for Colquitt Regional Medical Center to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purposes of treatment, payment and health care operations. You may refuse to sign this consent form.

You should read the Notice of Privacy Practices for protected health information made available to you by CRMC before signing this Consent. The terms of the Notice may change from time to time, and you may always get a revised copy of it by asking the CRMC Privacy Officer or the department/area where you are receiving treatment.

You have the right to request that CRMC restrict how your information is used or disclosed to carry out treatment, payment, or health care operations. PPHS is not required to agree to requested restrictions; if it does, however, the restriction is binding on it.

Your "protected health information" means health information, including your demographic information, collected from you and created or received by your physician, another health care provider, a health plan, your employer or a health care clearinghouse. This protected health information relates to your past, present or future physical or mental health or condition and identifies you, or there is a reasonable basis to believe the information may identify you.

Information about you is protected under federal law, and you have the right to revoke this Consent, unless we have taken action in reliance on your authorization (as determined by our Privacy Officer). By signing below, you recognize that the protected health information used or disclosed pursuant to this Consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

I acknowledge by placing my signature in the space provided that I have had access to the Notice of Privacy Practices and Notice of Individual Rights, and have read the above information.

If someone calls or visits and asks about you, can we acknowledge that you're here?
Yes ____ No____

_____ _____
Individual Signature Date

If a minor, this must be signed by parent or legal guardian.

As a personal representative, I have authority to act for the individual because I am the individual's

_____.
Parent or Guardian Signature