YOUTH 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 the Youth Volunteer Program at Colquitt Regional. We're excited that you're considering joining us in this meaningful opportunity to serve our patients, visitors, and staff while gaining exposure to the healthcare field. Below are the requirements and important information regarding the application process.

Minimum Qualifications

- Must between the ages of 14 - 18 and enrolled as a full-time student (entering 9th through 12th grade).
- Maintain a GPA of 3.0 or higher (a "B" average).
- Submit a letter of recommendation from a current teacher or school guidance counselor using the enclosed form.
- Demonstrate maturity and an interest in pursuing a healthcare career.

Application Procedure

1. **Complete and submit:**
    - The enclosed 2-page application.
    - A $15 application fee.
    - Background check consent forms.
    - Consent for the release of protected health information.
2. **School forms:**
    - Submit the enclosed *Permission for Release* form to be signed by both a parent/guardian and the student.
    - Provide the *Reference Form* and envelope to a teacher or school counselor. This form should be returned to you in a sealed envelope. Then submit along with your application.
3. **Return completed materials to:**
    - Volunteer Services Office (1st floor of the hospital),
      or mail to: *Volunteer Services @ CRMC,* P.O. Box 40, Moultrie, GA 31776

Once we receive and review your completed application and you meet our qualifications, we will contact you to schedule a group interview. These interviews are held monthly and include a program overview, expectations, benefits, and a hospital tour. Parents are welcome to attend.

If Accepted

If selected for the program, you will be required to:

- Pass a background check, if 17 years of age or older (form enclosed).
- Pass a health screening with our Employee Health nurse, which includes a physical exam, drug test and a TB skin test. *You must bring a copy of your immunization records to this appointment. A parent must also accompany you to this appointment.*
- Complete an online orientation course and pass a quiz on hospital safety and quality procedures.

- Commit to at least one shift per week (4–5 hours). Some shifts may be during weekends or evenings (e.g., 4–8 PM).
- Arrive on time for your shift.
- Attend bi-monthly YoVo meetings.
- Adhere to dress code: Black scrubs, sneakers, clean personal hygiene, no jewelry (a black scrub top will be provided for you)
- Wear your Colquitt Regional badge at all times and clock in and out for your shift.
- Avoid cell phone use during your shift.

Please note: Participation is limited and dependent on the availability of service positions.

Why YoVo?
There are many benefits to participating in Colquitt Regional'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.
- Scholarships
- Real work experience in the department of your choice.
- Learn communication and leadership skills.
- Make a great connection in your local community.
- 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 your Senior Honors Night program with a monetary award based on your accumulated hours served.

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**

We look forward to reviewing your application and hope you will join us in making a positive impact on our healthcare system.

Warm regards,
Nicole Stringer
Director, Volunteer Services

Colquitt Regional Medical Center

Youth Volunteer "YoVo" Application

[print]
NAME_____ **DATE**_____

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

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

SS# _____ **Birthday**_____/_____/_____ **Age** _____

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

Parent's Name _____

Have or are your parents employed at Colquitt Regional? _____

Shirt Size: _____

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.

_____

_____

_____

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SIGNED BY YOUTH:

If accepted into the Youth Program at Colquitt Regional, 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 I must 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 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 *Reference Form*

Name: _____ Date:_____

I have applied to be a youth volunteer at Colquitt Regional Health System. Please complete the reference form below and the additional comments section. The "Permission for Release of Confidential Information", signed by me 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.

[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 immunization 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 or No**

_____ _____

Individual Signature Date

_____

Parent or Guardian Signature