APPLICATION INSTRUCTIONS FOR 2019 SUMMER JUNIOR VOLUNTEER PROGRAM

Dear Student:

Thank you for your interest in our Junior Volunteer Program (non-paid) at Johns Hopkins Bayview Medical Center. To apply for the Junior Volunteer Program, please complete the enclosed four separate forms. Please read these instructions carefully, complete the forms as indicated, and turn in by March 11 by:

Fax: (410) 550-7068
Email: JHBMCVolunteers@jhmi.edu

1. The application form is to be completed by the student.

2. The consent & confidentiality statement form are to be read and signed by both student applicant and parent/guardian.

3. The PPD permission form is to be completed by the parent/guardian and presented to Occupational Health Services.

4. The teacher’s evaluation form is to be given to your teacher or counselor, for completion.

5. The letter of agreement form is to be read and signed by both student applicant and parent/guardian and returned at the time of your interview.

6. Documentation of medical requirements requested are to be submitted directly to Occupational Health Services.

After all required documents are received; you will be contacted to schedule an interview during the week of March 25 – April 12, 2019.

Thank you for your cooperation and for your interest in our program. If you have any questions, please call Kathy Pethakas, Administrative Assistant for Volunteer Services, at (410) 550-0627.

Sincerely,

Stellia Karais
Assistant Director, Volunteer Services/Patient Support
Johns Hopkins Bayview Medical Center
SUMMER JUNIOR VOLUNTEER PROGRAM APPLICATION
(PLEASE PRINT)

TODAY’S DATE________________________ PHONE#____________________________________

STUDENT’S FULL NAME____________________________________ BIRTHDATE______________

ADDRESS___________________________________________________________________________

CITY___________________ STATE_______ ZIPCODE___________ EMAIL_____________________

SCHOOL________________________________________________ GRADE__________

PARENT’S NAME________________________________________________________

PARENT’S EMPLOYER________________________________ PHONE______________________

PERSON TO BE NOTIFIED IN CASE OF ILLNESS/EMERGENCY AND RELATIONSHIP:

NAME________________________________ RELATIONSHIP______________________________

PHONE: CELLPHONE________________ HOME________________ WORK_____________________

[ ] RETURNING VOLUNTEER - Area you volunteered last summer: __________________________

If you do not want to volunteer in the area you did last summer, please give a first and second choice of where you would like to volunteer. We will try to accommodate you.

1st CHOICE________________________________ 2nd CHOICE____________________________

[ ] NEW VOLUNTEER - POSITION DESIRED: _____INPATIENT AREA_____OUTPATIENT AREA

VOLUNTEER DAYS DESIRED: (Suggest 2-3 days per week, between 8:00 a.m. to 4:30 p.m., NO weekends)

DAYS AVAILABLE TO VOLUNTEER: M ____ T ____ W ____ TH ____ F ____ HOURS: From ___:___ am To ___:___ pm

*Please note that every effort will be made to accommodate your request. However, volunteer position availability varies.

SIGNATURE OF STUDENT __________________________________________________________ DATE_____________________

*MY SON/DAUGHTER/WARD HAS MY PERMISSION TO PARTICIPATE IN THE JUNIOR VOLUNTEER PROGRAM AT JOHNS HOPKINS BAYVIEW MEDICAL CENTER.

PARENT/GUARDIAN SIGNATURE___________________________________________________
JUNIOR CONSENT & CONFIDENTIALITY FORM

Your son/daughter has expressed an interest in serving as a junior volunteer at Johns Hopkins Bayview Medical Center. Please read and discuss with your son/daughter the Volunteer Employment Agreement and Confidentiality Statement below. If this meets with your approval, please sign the consent form and return this form and application to Volunteer Services.

Stellia Karais
Assistant Director, Volunteer Services/Patient Support

JUNIOR VOLUNTEER AGREEMENT

I, ____________________________ (Student’s Name), agree to comply with the following rules while at Johns Hopkins Bayview Medical Center. I understand that failure to obey the following rules will lead to my dismissal from the program.

1. I will report to work on time.
2. I will sign-in at the designated place when I arrive and I will sign out when I leave.
3. I will dress professionally and wear the uniform and ID badge that is issued to me at all times when volunteering at Johns Hopkins Bayview Medical Center.
4. I will not smoke while in uniform and on Medical Center grounds.
5. I will be punctual, courteous, and neat; and I will treat this assignment as a job experience.
6. I will notify the Volunteer Office and my unit/department of any absences.
7. I will respect all patients’ rights to privacy and confidentiality.
8. I will follow all Medical Center regulations.
9. I will behave in a professional manner at all times.

STUDENT’S SIGNATURE __________________________________________ DATE ____________

CONFIDENTIALITY STATEMENT

I, ____________________________ (Student’s Name), understand that during the normal course of working for Volunteer Services at Johns Hopkins Bayview Medical Center, or other hospital-related activities, I may have access to confidential patient-specific and health care provider medical information from medical records or elsewhere. This medical record or other information is highly confidential. I understand that I am expected to respect the confidentiality of this information and that I am indirectly, or by implication, not to repeat any of the patient-specific or health care involved with the above-described functions. I understand that my violation of the provisions of this Confidentiality Statement may result in legal sanctions or in disciplinary action against me.

JUNIOR VOLUNTEER SIGNATURE __________________________________________ DATE ____________

PARENT/GUARDIAN SIGNATURE __________________________________________ DATE ____________
Junior Volunteer Letter of Agreement

- I accept the invitation to volunteer at Johns Hopkins Bayview Medical Center in the 2019 Summer Junior Volunteer Program.

- I will participate in the orientation program scheduled on June 18, 2019, from 9:30 a.m. to 2:30 p.m. in the Carroll Auditorium on the first floor of the “AA” building.

- I agree to volunteer from June 19, 2019, to July 29, 2019, unless previous arrangements were made.

- I accept responsibility for obtaining and reporting all necessary documentation for my school.

- I understand that I will be dismissed from my volunteer position if I fail to comply with the Junior Volunteer Program standards.

- Beyond the duties specified in my position description, I pledge to serve as an ambassador on behalf of Johns Hopkins Bayview Medical Center.

_______________________________
Junior Volunteer’s Signature

_______________________________
Parent/Guardian Signature

Date

Date

I have discussed the above letter of agreement with my son/daughter/ward.

*Please return this document to Volunteer Services at the time of your interview.*
Medical Information Required

**PROVIDE PROOF OF AND SUBMIT TO OCCUPATIONAL HEALTH:**

☐ **TWO MMR** vaccinations (*Measles, Mumps, and Rubella*). You must show proof that you have had 2 doses of MMR. Titers (blood work showing the immunity levels) are acceptable in lieu of vaccination records.

☐ **TWO CHICKEN POX** (*Varicella*) are required either through immunization record, physician certification of chicken pox or proof by titer. Titers (blood work showing the immunity levels) are acceptable in lieu of vaccination records.

- If your immunization record only notes a history of the disease for Varicella, you must have a titer (blood work done at your own expense) to show you developed an immunity to the disease.

- If you have only had half of each vaccination series (*1 MMR and/or 1 Varicella*), you must consult with your doctor on finishing the series or having blood work drawn to show immunity.

☐ **THREE Hep-B**

☐ **ONE Tdap** (or **FIVE dTap**)  

☐ **ONE PPD/TB** (*Tuberculosis*) tests within the last 12 months, or if positive PPD, Chest X-Ray or T-Spot within last 6 months.

  - Occupational Health administers PPD tests Monday-Friday (*Except Thursdays, free of charge*). You will have to return to Occupational Health 2 days later to have it read (*Ex. Placed on Monday read on Wednesday*). Please bring completed PPD Permission Form to the Occupational Health office.

  - If you have had a TB test done within the last year please bring those records with you to Occupational Health.

*If you have any questions, please call Volunteer Services (410) 550-0627 or Occupational Health (410) 550-0477, (Fax: 410-550-0732).*
PPD Permission Form

Dear Parent/Guardian,

Tuberculin screening is done to ensure freedom from communicable disease, determine baseline tuberculin status, detect early evidence of disease, which might require treatment and protect patients and employees from cross infection.

The Johns Hopkins Bayview Medical Center has determined that tuberculin screening will be done on each volunteer before their first day of work. A tuberculin test will be administered to volunteers who indicate a history of negative reaction to tuberculin testing. Volunteers who have had a positive reaction to a previous tuberculin test will have to have an x-ray administered by their personal doctor.

These testing procedures are mandatory conditions of continuing employment and employees who fail to comply will be subject to dismissal.

If you have any questions, please call Occupational Health Services at 410-550-0477.

I have read and understood the information presented above and give permission for

__________________________________________________________________________to receive the tuberculin test.

Full Name (PLEASE PRINT)

Parent/Guardian Signature_____________________________________________________

Print Name_____________________________________________________________________

Relationship________________________Date____________________

*Please return this form to:
Occupational Health Services
Alpha Commons Building
5300 Alpha Commons Drive
Baltimore, MD 21224
Telephone: (410)-550-0477
Fax: (410)-550-0732.
TEACHER EVALUATION FORM

Student Name__________________________________________

Last                                                                            First
Middle

Permanent Address___________________________

Number and Street ____________________________

City                                              State                              Zip Code

Phone#____________________________________________________

Age_______ Grade_________________________

Teacher’s Name________________________________________

Official School Name_________________________________

Circle the correct number:

1-Poor                2- Needs Improvement          3-Satisfactory          4-Very Good          5-Excellent

1. Leadership
2. Relates well with peers
3. Relates well with adults
4. Follows directions
5. Well organized
6. Dependable
7. Neat appearance

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Comments:_______________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

Teacher’s Signature__________________________________________ Date________________

Please FAX to: (410) 550-7068
EMAIL to: JHBMCVolunteers@jhmi.edu

If you have any questions, please call:
Kathy Pethakas
Administrative Assistant, Volunteer Services
(410) 550-0627
Stellia Karais
Assistant Director, Volunteer Services/Patient Support