Providence Holy Cross Medical Center
Volunteer Services
15031 Rinaldi Street
Mission Hills, CA 91346-9600
(818) 496-4613
PHCMC.Volunteers2@providence.org

PROVIDENCE
Holy Cross
Medical Center

Dear Teen Volunteer Applicant:

Thank you for your interest in volunteering at Providence Holy Cross Medical Center (PHCMC). Our teen volunteers are an important part of our volunteer program. They provide an extra element of energy and caring for our patients and staff. As a volunteer you will have an opportunity to learn the value of commitment and responsibility, as well as gaining important work experience for use on college resumes and work applications. You may also be able to use your hours worked for high school community service.

Please read this letter carefully as it contains the requirements you must meet to become a volunteer. You must be between 15 and 17 years of age, attending high school and maintain a GPA of 2.0 or higher (no exceptions)

- **You must commit to volunteering 150 hours for a minimum period of twelve months.**
- **You must obtain two recommendations from a teacher or guidance counselor written on school letter head. The letter should reference your good character, grades and citizenship.**
- **You must have a signed parent consent form.**
- **All assignments are based on the needs of the hospital. However, we will attempt to place you in the area of your choice whenever possible.**
- **If you are involved in after school activities such as sports, clubs or student music program, you may need to consider whether you have the time to volunteer in a medical center.**
- **<u>Our volunteer program requires a year round commitment</u> and does not allow for volunteering during summer months only.**
- **Three unexcused absences during this time may result in possible termination from the volunteer program.**

To be considered an excused absence you will need to notify your department at least 24 hours in advance by phone or email and have a valid reason for missing your shift. Offer your services only if you intend to do your best, have the time and ability to do so throughout the year, and can accept guidance and supervision with enthusiasm.

In order to participate in our volunteer program a parent or guardian must approve your volunteer participation and you need to provide a written recommendation from a teacher or counselor and submit it with your application. You will also need to have a stable telephone number with a voice mail that you check in order for us to communicate with you. Also please be sure to check your email as we do communicate by email much of the time.

You will complete a personal interview and if accepted as a volunteer you will undergo a tuberculosis screening done by our employee health department at no cost to you, and attend a three hour orientation before you begin to volunteer. **If accepted to our program, you will need to purchase a uniform for $25.00.** You will purchase your uniform at your second appointment. This charge is non-refundable. On average the complete on boarding process can take several months to complete. Since there are a limited number of assignments available for teens, there is often a waiting list.

Please fill out and return the application, the parent consent letter and the reference form. **You may return it to us by mail, email or you may drop it off at the information desk in the lobby of the Hospital**. We will contact you by email to schedule an interview *if openings become available*. You should receive an email within four weeks. If you have any questions, please feel free to call me at (818) 496-4613.

Sincerely,

Pamela Wegner

Pamela Wegner
Sr. Manager of Volunteer Services
Providence Holy Cross Medical Center

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Dear Parent/Guardian,

It is necessary that we have the cooperation of our teen volunteer's parents. Parents make sure that the teen can get to their volunteer assignments as scheduled and on time. If your child is accepted to the volunteer program, a **minimum commitment of 150 hours of service over a twelve month period is required.** Therefore, we ask that the student offers their services only if they are able to complete this requirement.

Once your teen receives his/her volunteer schedule, he/she needs to consider volunteer time as a priority as the department to which the teen is assigned depends on the volunteer completing their duties. Social plans, doctor or dental appointments and vacation, etc. should be planned around the volunteer schedule. Teen volunteers who miss their appointed schedules more than 3-times, except for a serious reason, are subject to termination.

A high rate of absence by teen volunteers will not make our teen program viable; therefore, we will be very strict about adhering to schedules. Even though the teens are giving of their time, which is definitely needed and appreciated, there is expense by the hospital for the TB testing, background checks and training of each volunteer.

Student volunteers will begin their involvement with the hospital by working in various areas throughout the medical center. Some of these assignments may include:

- General office work in various hospital departments
- Information desk and or patient escort
- Gift Shop
- Nursing or patient care units are assigned to teens once they have volunteered for a period of time and have proven themselves to be dependable and reliable.

Again, please help your teen to recognize that committing to be a volunteer requires obligation and should be a priority.

Sincerely,

Pamela Wegner

Pamela Wegner
Director Volunteer Services

Please review and sign the back of this form

I agree: My services are donated to Providence Health System voluntarily without any expectation whatsoever of compensation, future employment, or benefits and given with purely humanitarian or charitable reasons.

To hold as absolutely confidential all information which I may obtain directly or indirectly concerning patients, families, physicians, or personnel, and i will not seek confidential information in regard to a patient.

To serve at least 150 hours over a period of 12 months. (approximately 13 hours per month) I will not receive documentation of my hours until I have met the minimum requirement

I certify that the answers given by me to the foregoing questions and statements are true, correct and without omissions. I authorize providence health system to investigate and/or verify the foregoing information and any other information which might assist them in determining my qualifications for volunteering.

I release Providence Health System and my former employers, and all others from any liability from damage which may result from such investigation if, upon investigation, anything contained in this application is found to be untrue.

I agree to conform to the rules and regulations of this facility. I understand that my volunteer status at any providence health system hospital can be terminated at any time for failure to comply with the policies, rules and regulations of the hospital including those of the volunteer department.

Any person who intentionally gives misleading or false information will be subject to immediate termination.

FOR TEEN VOLUNTEER APPLICANTS:

To Parents: It is necessary that we have the cooperation of our teen volunteer's parents by making sure that they can get to their volunteer assignments as scheduled and on time. Once your teen receives his/her volunteer schedule, he/she needs to consider volunteer time as a priority as the department to which the teen is assigned plans on the volunteer being there. Social plans, doctor or dental appointments and vacations, etc. should be planned around the volunteer schedule. Teen volunteers who miss their appointed schedules more than 3-times, except for a serious reason, are subject to termination.

Please help your teen to recognize that committing to be a volunteer requires obligation and should be a priority.

As a parent to _____ I have read the above letter regarding my teen's commitment to being on time and available for the volunteer assignment agreed upon and will make sure that my son/daughter has the available time and transportation to complete his/her commitment.

Parent's Signature:	**Date:**
Applicant Name: print	
Applicant Signature:	**Date:**

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APPLICATION FOR TEEN VOLUNTEER SERVICE

Providence Health & Services Los Angeles Service Area welcomes individuals of all backgrounds and abilities and does not judge applicants by race, religion, age, national origin, or disability; but rather by commitment, dependability, and the desire to be of service.

TODAY'S DATE:		DATE AVAILABLE TO START:	
LAST NAME		FIRST	MI
STREET ADDRESS			
CITY		ZIP CODE	
HOME PHONE		CELL PHONE	
		WORK PHONE	
DATE OF BIRTH:	MONTH	DAY	YEAR
E-MAIL ADDRESS			
Have you ever been an employee or volunteer of Provide Holy Cross or St. Joseph Med Ctr? Yes or No			
EMERGENCY CONTACT INFO:			
NAME		RELATIONSHIP	
ADDRESS			
CITY	STATE	ZIP	
HOME PHONE	WORK PHONE	CELL PHONE	
EMPLOYMENT (If any) : ____ Current _____ Last			
Company		Position	
Address		Phone	
SCHOOL INFORMATION			
SCHOOL		ADDRESS	
PHONE	**GRADUATION YEAR**	**GPA**	
ARE YOU VOLUNTEERING TO FULFILL A CLASS REQUIREMENT FOR COMMUNITY SERVICE CREDITS? No Yes			
IF YES, NUMBER OF HOURS REQUIRED		REQUIRED DATE OF COMPLETION	
NAME OF SCHOOL, CLASS, OR OTHER ORGANIZATION REQUIRING COMMUNITY SERVICE HOURS:			
Volunteers may be asked to assist staff with translating information to patients/families. If you are willing to assist with translation, please complete this section.			
Language(s):		Can you read/write in this language? Yes No	

How did you learn about the volunteer program at PHCMC?

Have you ever applied here before?

Previous or current volunteer experience?

I agree to the 150 hour and twelve month minimum commitment. Signature:

How many hours per week will you be volunteering?

Please circle the days, and indicate the time of day, you are available to volunteer:

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
TIME							

Preference of Volunteer Service: CLINICAL OFFICE OTHER:

Skills or Experience:

Do you have family of friends who work or volunteer in our medical center? Yes No

If so, who?	Where?

VOLUNTEER AGREEMENT AND CERTIFICATE OF INFORMATION

Believing that Providence Holy Cross Medical Center (herein referred to as PHCMC) has need of my volunteer services I agree to:

- Hold as absolutely confidential all information, which I may obtain directly or indirectly concerning Providence Holy Cross Medical Center, its patients/families, staff, physicians and volunteers. I will not seek confidential information in regard to a patient.
- Donate my services to Providence Health System without contemplation of compensation, or future employment.
- Serve at least 150 hours over a minimum of a twelve month period

I certify that the answers given by me to the foregoing questions and statements are true, correct, and without omissions. I authorize Providence Health System to investigate and or verify the foregoing information, and any other information, which might assist them in determining my qualifications for volunteering. I release PHCMC and my former employers, and all others from liability from damage which may result from such investigation, if upon, such investigation, anything contained in this application is found to be untrue. I further agree to comply with the rules and regulations, as well as safety practices in all areas of PHCMC. I understand that my volunteer status may be terminated at any time for failure to comply with policies and procedures of PHCMC including those of the Volunteer Services Department, for absence without notification, for reasons of unsatisfactory attitude, work, personal appearance, and for any other circumstances which, in the judgment of PHCMC would make my continued service as a volunteer contrary to their best interests. I also understand that no one has any authority to enter into any agreement for employment for any specified period of time or to make any agreement contrary to the foregoing, except for an employment agreement signed by an administrative representative of this facility. ANY PERSON WHO KNOWINGLY GIVES FALSE INFORMATION WILL BE SUBJECT TO IMMEDIATE DISMISSAL.

Printed Name

Signature	**Date**
Parent Signature	**Date**

DO NOT WRITE BELOW THIS LINE – OFFICE USE ONLY

Date Application received:	Interview Date:
Orientation Date:	Safety Quiz:
Start Date:	TB:
Uniform Paid:	ID Badge Recd:
HIPAA:	Background Check:
Assigned Department	Dept Checklist
Days and Hours	
Signature, Volunteer Services	Date:

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Volunteer Applicant's Personal Statement

Name: _____ **Date:** _____

(Attach additional sheets if necessary)

1. Why are you interested in volunteering at Providence Holy Cross Medical Center?
2. What do you expect to gain from this experience?
3. Please describe your short-term goals.
4. Please describe your long-term goals.

Signature: _____ Date: _____

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Reference for Teen Volunteer

This section is to be completed by the TEEN Volunteer Applicant then given to a teacher, guidance counselor, clergyman, or other person (excluding family member) who has knowledge of this individual's personal traits.

Last Name	First Name	Middle Initial
Name of School		
School Street Address		
City	State	Zip Code
Current Grade Level	Graduation Year	GPA

Dear Sir/Madam:

Please provide a reference for the above applicant on your organization's letterhead.

- ☐ Please take note that the student must be attending high school grades 9 through 12, and have at least a 2.0 GPA. The student should not have any "Unsatisfactory" ratings in cooperation or citizenship in the current school year.
- ☐ The student must be mature in order to take direction and perform volunteer duties as assigned by the Providence Holy Cross Medical Center and its designated staff.
- ☐ Please do not give references for students you do not know well.
- ☐ Please return your recommendation to your student or mail it directly to:

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Thank you so much for your assistance.

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Last Name	First Name	Middle Initial
Name of School		
School Street Address		
City	State	Zip Code
Current Grade Level	Graduation Year	GPA

Dear Sir/Madam:

Please provide a reference for the above applicant on your organization's letterhead.

- ☐ Please take note that the student must be attending high school grades 9 through 12, and have at least a 2.5 GPA. The student should not have any "Unsatisfactory" ratings in cooperation or citizenship in the current school year.
- ☐ The student must be mature in order to take direction and perform volunteer duties as assigned by the Providence Holy Cross Medical Center and its designated staff.
- ☐ Please do not give references for students you do not know well.
- ☐ Please return your recommendation to your student or mail it directly to:

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Thank you so much for your assistance.