AtlantiCare
A MEMBER OF GEISINGER HEALTH SYSTEM

Dear Student,

Thank you for your interest to volunteer at AtlantiCare. Junior volunteers ages fourteen through seventeen (must be age fourteen before January 1) are an important part of our team providing support in the Medical Centers and satellite offices to help deliver exceptional service to the communities we serve. We are grateful that you will share your talents with us, and want your experience as a volunteer to be a rewarding one. PLEASE NOTE: All communication will be via e-mail so please check your spam folders.

Applications are accepted between September 1 and November 1 for juniors interested in volunteering during the school year. Acceptance of juniors for volunteering during the school year is at the discretion of the Volunteer Services Department. Juniors must be scheduled to start volunteering before January 31, or they must reapply to be considered for the summer program. **ALL JUNIORS ARE REQUIRED TO COMPLETE WORKING PAPERS TO VOLUNTEER**, which are attached.

Attached please find:

1) A Junior Volunteer application (2-pages)
2) Parental Permission Form and Criminal Background Clearance Form
3) Privacy/Confidentiality Agreement Form
4) Photo Release/Release of Information to the Media
5) New Jersey Working Papers – **complete Section A and bring with you to the Information Meeting for our signature**
6) Occupational Medicine Questionnaire for your TB testing – **to be brought to your Occupational Medicine meeting**
7) In addition we require the status of the following immunizations: MMR, Varicella, Dtap/Tdap, Influenza. All junior volunteers are required to have a 2-step PPD test for tuberculosis, which AtlantiCare provides at no cost to you through our Occupational Medicine Department. At the Information Meeting/Group Interview (explained below) you will receive an Authorization for Services form to receive the TB testing and to have your immunization records reviewed. **You will need to bring your immunization records with you when you attend your Occupational Medicine appointment.** PLEASE NOTE: If you had a PPD test done within the past year, please bring the proof of the testing results to your Occupational Medicine appointment.

DO NOT SEND THE WORKING PAPERS, YOUR IMMUNIZATION RECORDS, OR OCCUPATIONAL MEDICINE QUESTIONNAIRE WITH YOUR APPLICATION.

When we receive your completed application, you will be invited to an information meeting/group interview. One of your parents must attend with you. **Only the junior applicant and their parent(s) may attend the meeting. Please bring your Working Papers, with Section A completed, with you to the Information Meeting.** At the meeting you will be photographed for your ID badge, we will sign your Working Papers, and you will receive an Occupational Medicine Authorization Form. When Occupational Medicine clears you to volunteer, you will be sent, via e-mail, an online orientation to view with assessment to complete. The final step will be meeting with you at a mutually agreeable date/ time to discuss volunteer opportunities, plan your schedule, and you will receive your ID badge and volunteer shirt. Applications may be sent to VOLUNTEER SERVICES, ARMC Mainland Division, 65 W. Jimmie Leeds Road, Pomona, NJ 08240, dropped off at the front desk at AtlantiCare Regional Medical Center Mainland Division, or faxed to 609-404-7478.

SUMMER JUNIOR VOLUNTEER PROGRAM

Applications for the Summer Junior Volunteer Program are accepted between January 1 and April 15. There are a maximum number of students accepted into the summer program. Acceptance is based on the date the application is received in the Volunteer Services Department or until the program is full, which could be before April 15.

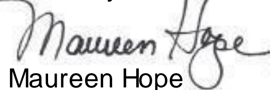
Juniors accepted for the summer volunteer program will receive a letter after April 15, with dates of the Information Meetings/Group Interviews. You must register for one of the meetings and attend with one of your parents. Only the junior applicant and their parent(s) may attend the meeting. At the meeting you will be photographed for your ID badge, and we will sign your working papers. Nurses from Occupational Medicine will be at all the meetings for the TB testing and to review your immunization records. **Please complete the Occupational Medicine Questionnaire included with the application, and bring it with you to the information meeting, along with your Working Papers with section A completed.**

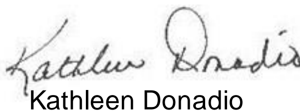
> INFORMATION ABOUT THE TB TESTING – Step 1 of the PPD test is the injection of a serum in a subdermal section of your forearm. Two days after the placement, you need to return to have the area of the injection looked at, and the nurse will sign and date a form noting the results. The second part of the 2-step PPD testing must be done between 1 and 3 weeks after the first placement. It is the same process as the Step 1. A 2-step PPD is four visits to Occupational Medicine.

When you have been cleared to volunteer by Occupational Medicine, you will be sent via e-mail, an online orientation to view with an assessment to complete. When you have completed the Assessment, you will with meet with Volunteer Services at a mutually agreeable time to discuss the volunteer opportunities available, plan your schedule, and receive your ID badge and volunteer shirt.

Your contribution as a volunteer is invaluable and we look forward to the opportunity to work with you. Thank you.

Sincerely,





Maureen Hope — Kathleen Donadio

Volunteer Services Department

Phone: 609-404-7477 — Phone: 609-407-2029

maureen.hope@atlanticare.org — kathleen.donadio@atlanticare.org

Fax: 609-404-7478

JUNIOR VOLUNTEER APPLICATION (ages 14 through 17)

**** PLEASE NOTE: WORKING PAPERS ARE REQUIRED FOR ALL JUNIOR APPLICANTS**

Date:_______________________________ Name:____

First Middle Initial Last

Date of Birth:________________________ E-Mail Address:____

Street Address:____

City:_____________________________________ State:________________________ Zip Code:__________________________

Home Phone Number:________________________________ Cell Phone Number:___________________________________

Name of School Currently Attending:____

Street Address of School:____

City of School::____State:________________________ Zip Code:______________

Parent/Guardian Name:____

E-Mail Address for Parent/Guardian:____

Preferred Phone Contact for Parent/Guardian:____

How did you hear about volunteering at AtlantiCare?____

Have you volunteered at AtlantiCare in the past? ☐ No ☐ Yes If yes, in which department(s)?___________________

____

Do you have any previous hospital or community volunteer experience? ☐ No ☐ Yes If yes, please list where :_____

____

____

Do you speak another language? ☐ No ☐ Yes If yes, what languages?_____________________________________

____

Please tell us why you would like to be an AtlantiCare volunteer?

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AtlantiCare
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How would you like to volunteer with AtlantiCare?
Role descriptions are available on the website

(**Volunteer opportunities are based on department needs and volunteer skills. Please check all areas of interest.)**

- ❑ Interacting with patients (e.g. visiting patient rooms, sitting with patients to offer companionship, hospitality cart)
- ❑ Interacting with the public (e.g. information desk, hospital greeter/guide, registration, accompanying musicians/pet visits throughout the hospital)
- ❑ Dietary (help in the kitchen, cafeteria, dining area, catering)
- ❑ Logistics (e.g. restocking, rotating inventory, delivering supplies)
- ❑ Clerical help (e.g. filing, computer data entry, assembling information packets, phone support, laminating, mailings)
- ❑ Creative Arts and Healing Program (e.g. musicians, licensed pet therapy, etc. to visit patients or perform in lobbies)
- ❑ Other interests for volunteering? Please explain:______________________________________

____

____

Junior Volunteers are typically scheduled for a three hour shift, once a week.

A letter of Acknowledgement of Volunteer Service is presented to students who volunteer a minimum of 30 hours.

JUNIOR VOLUNTEER PARENTAL PERMISSION FORM and CRIMINAL BACKGROUND CLEARANCE

I hereby grant permission for my son/daughter:____
PLEASE PRINT NAME

to participate in the Junior Volunteer program at AtlantiCare. I understand that participants must be between the ages of 14 and 17. My son/daughter will attend an Information Meeting/Group Interview with one of his/her parents and complete an orientation. My son/daughter is expected to follow AtlantiCare's policies and procedures. I will assume full responsibility for my son/daughter and, thereby, release AtlantiCare from any obligation, which may be incurred by him/her performing volunteer work on behalf of AtlantiCare.

AtlantiCare requires a criminal background clearance prior to individuals becoming part of our volunteer team. In lieu of a criminal background clearance for a Junior Volunteer, I hereby attest that my child is a minor and has not been convicted of a crime.

Please print Junior Volunteer's name:____

Signature of Junior Volunteer:____

Please print parent or guardian name:____

Signature of parent or signature:____

Date:____

Information Security Privacy/Confidentiality Agreement to Abide By AtlantiCare's Notice of Private Practices and *AtlantiCare Notice and Privacy Practices and AtlantiCare Policy*

Important

Read all sections carefully before signing. AtlantiCare will retain a copy of this agreement.

Agreement to Abide by AtlantiCare's Notice of Privacy Practices:

During the normal course of my junior volunteer assignment within AtlantiCare, I may come in contact with information that is private and confidential and is proprietary to patient(s) and/or AtlantiCare s Health System. Information is defined as all patient, employee, physician, healthcare provider and/or other data concerning AtlantiCare Health System and its related entities which appear in verbal, written, or electronic form.

I understand that AtlantiCare will utilize one Notice of Privacy Practices for all of AtlantiCare's business entities which will include members of AtlantiCare's junior volunteer staff. Junior volunteers must abide by AtlantiCare's Notice of Privacy Practices and AtlantiCare policy while on the premise of any AtlantiCare business entity.

I acknowledge that disclosure of confidential protected health and/or proprietary AtlantiCare Health System information may violate regulatory requirements, state, or federal laws and accreditation standards.

I understand that AtlantiCare Notice of Privacy Practices is essential in maintaining patient protected health information, as outlined within the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I will comply with AtlantiCare's policies protecting information security and the privacy/confidentiality of patient information.

I hereby acknowledge that I have review, understand, and will follow AtlantiCare's Notice of Privacy Practices and AtlantiCare's Information Security Policies and Procedures while a junior volunteer at any AtlantiCare business entity.

Date:____

Print Volunteer's Name:____

Volunteer's Signature:____

Print Parent/Guardian Name:____

Parent/Guardian Signature:____

Photo Release/Release of Information to the Media

I hereby grant permission to AtlantiCare, its employees and assigns and/or outside media to photograph, videotape or interview me and/or my dependent(s) on various dates throughout Junior Volunteer Career/Service. The specific information to be released to the media or AtlantiCare includes:

□ Photos □ Videos □ Interview □ Other, describe:

Junior Volunteer Program Activities ____

____

____

____

I understand that the photographs, videotape or interview shall become the property of AtlantiCare and/or the outside media and that I shall not have any rights to the same. I also understand that I will not be compensated for participating in the taking of photographs, videotaping or interviewing and that I will not be entitled to compensation as a result of the broadcast or publication of the photographs, videotape or interview.

I understand that the photographs, videotape or interview may be used and redisclosed as a press release and shared with media for possible publication or broadcast. I also understand that the photographs, videotape or interview might be publicized or broadcast, or used in promotional materials that include, but are not limited to, brochures, billboards, advertisements, the AtlantiCare Internet site and the AtlantiCare Intranet site. I understand that the photographs, videotape or interview might be edited and I agree that AtlantiCare, its employees and/or agents shall have the right to, at any time, add to, edit, arrange, rearrange and/or revise such photographs, videotape or interview. I understand that AtlantiCare maintains the right to reuse the photograph, videotape, or interview for future purposes without additional authorization or release.

I release AtlantiCare, its employees and agents from any and all claims and from all liability including, without limitation, claims for libel, invasion of privacy and/or misappropriation of likeness arising out of the interviewing, photographing or videotaping and subsequent publication or broadcasting of this material. I understand that I am not required to sign this authorization and that AtlantiCare will not condition treatment on my execution of this authorization. I understand that I have the right to revoke this authorization at any time prior to AtlantiCare's compliance with the request. The revocation must be in writing and is subject to terms described in AtlantiCare's Notice of Privacy Practices and other AtlantiCare policies.

I understand that the terms of this authorization are governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable state and federal regulations and that the information disclosed by this authorization may be redisclosed by the recipient and will no longer be protected by HIPAA. This authorization will expire September 1, 2072.

Volunteer's Name (please print): ____

Signature: ____

IF SUBJECT IS A MINOR:

Name of Parent/Guardian (please print): ____

Signature OF Parent/Guardian: ____

Office Use Only - Description:

____

____

____

TUBERCULOSIS SKIN TESTING CONSENT

I, ____________________________, am presenting myself for Tuberculosis skin testing by AtlantiCare Occupational Medicine. I voluntarily consent to this procedure and understand the purpose of such procedure.

____________________ ______________________________________
Date Jr. Volunteer Signature

____________________ ____
Date Parent/Guardian Signature

Acknowledgment of Privacy Notice:
I understand and have been provided with AtlantiCare's *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. AtlantiCare reserves the right to make changes to their Privacy Notice. Revised copies are available at all patient registration areas. By signing this form, I acknowledge that I have been afforded the opportunity to consider AtlantiCare's Notice of Privacy Practices prior to signing of this consent and making of healthcare decisions.

___________________ ____
Date Jr. Volunteer Signature

__________________ ____
Date Parent/Guardian Signature

TUBERCULOUS SKIN TESTING PRESCREEN – HISTORY

1. Have you ever had an allergy to tuberculin or the components derivative (PPD)?

   [ ] Yes [ ] No

2. Have you had a live viral vaccine or taken systemic steroids within the past 4 weeks?

   [ ] Yes [ ] No

Do you have a history of the following?
[ ] A BCG vaccine
[ ] A positive PPD skin test
[ ] Active tuberculosis
[ ]Treatment with preventative therapy (prophylaxis) for active tuberculosis

4. When was your last PPD done? _____________________________________

ATLANTICARE JR. VOLUNTEER

TUBERCULOSIS SKIN TESTING ADMINISTRATION RECORD

Name ______________________________________ **Date of Birth**_______________

****

PPD Skin Test Administration

Initial Mantoux:

Date tested ____________________
Site: R_____ L ______forearm
Administered by ____________________
Lot# _________Exp. Date___________

PPD Skin Test Reading

Date to be read ______________________
Date read ______________________
Results __________mm
Read by ______________________

2 Step:

Date tested _____________________
Site: R_______ L ______ forearm
Administered by ___________________
Lot# _________Exp. Date __________

Date to be read ________________________
Date read ________________________
Results __________mm
Read by ________________________