UF Health Leesburg Hospital, 600 East Dixie Avenue, Leesburg, FL 34748 (Phone: 352.323.5060)
Please return completed application to the hospital or email to: jwoods@shands.ufl.edu

TEENAGE VOLUNTEER (TAV) APPLICATION FORM

This application is for volunteer service purposes only and is not valid until received and reviewed by the Auxiliary Committee and the UF Health Leesburg Hospital Foundation. UF Health Central Florida is committed to providing a safe and healthy environment for everyone on campus. Prior to volunteer orientation & assignment, applicants must pass all applicable background screenings.

Application Date:				
Last Name:		**First**		**Middle**
Present Address:	**Street**	**City**	**State**	**Zip**
Home Telephone:		**Cell Phone:**		
Name of Father/Guardian & Phone:		**Name of Mother/Guardian & Phone:**		
Date of Birth:	**Age:**	☐ **Female**	☐ **Male**	
Social Security Number:		**Driver License #:**		
Family Members working at UF Health Leesburg Hospital? ☐ **Yes** ☐ **No** **Dept:**				
Email Address:				

VOLUNTEER EXPERIENCE/COMMUNITY AFFILIATIONS

How did you hear about the Volunteer Services program with UF Health Leesburg Hospital?
____

Do you have previous volunteer experience? ☐ **Yes** ☐ **No**
Where and When:
____
____

EMERGENCY CONTACT

Name:____

Relationship:____

Home Phone: _______________ **Cell Phone:**_____________________

Please return the following documents. We will call you for a personal interview.

1. **Completed and Signed Application**
2. **Two letters of Personal References**
3. **Parental Permission Form Completed and Signed**
4. **Tuberculosis Permission Form Completed and Signed**

Signature:____________________________________ **Date:**___________________

FOR OFFICE USE ONLY

Application Received: ___________ **Interview Date:**____________ **Interviewed By**:_____________

Scheduled Orientation Date: ___________ **Start Date**:___________

Assignment:______________________________

Comments:____

PARENTAL PERMISSION to VOLUNTEER

I hereby agree to allow my son/daughter ____________________________ to serve as a Teen Volunteer with UF Health Leesburg Hospital (the hospital) auxiliary. I release the hospital from any responsibility or liability for any unforeseen results or causes that may arise as a result of my teenager's service. Further I hereby agree to hold harmless the hospital and the auxiliary and agree to indemnify, defend and hold harmless the hospital, the auxiliary, its officers, directors, employees and representatives from any and all liabilities and claims resulting solely from or attributable to acts of omissions of my son/daughter in the performance of these services.

1. It is mutually understood and agreed that your son/daughter is not an employee of the hospital. The sole interest and responsibility of the hospital is to ensure that the services provided by your son/daughter shall be consistent with the standards of care provided by the hospital and are consistent with the policies and procedures of the hospital and that my son/daughter performs and renders service in a competent, efficient and satisfactory provision of medical care at the hospital.
   _____ Parent's Initials

2. At the hospital's sole discretion, the hospital may provide written notice to you that your son/daughter's work with patients or personnel is not in accordance with acceptable procedures or standards of performance or otherwise could disrupt patient services of the hospital and remove your son/daughter from the hospital.
   _____ Parent's Initials

3. Upon request, your son/daughter may be requested and shall provide the following required documents to the hospital or cooperate with the hospital to obtain these documents prior to start or while volunteering:
   a. Application of volunteer
   b. Health screening including: TB skin test or chest x-ray, proof of MMR immunity or vaccination, Free of Communicable Disease statement.
   c. Agreement to comply with the Security and Privacy Policy **_____ Parent's Initials**

4. I am responsible for the transportation of my teen to/from the hospital as well as the purchase of the required uniform. (Photo ID Badge will be provided by the hospital). **_____ Parent's Initials**

5. I understand that my teen must commit to a minimum of 4 hours per week and must attend a new Teenage Volunteer Orientation before beginning volunteer service. I also understand that volunteer service assignments may ***only*** be made by the Teen Volunteer Coordinator. My teen may ***only*** report for volunteer service as assigned. If your teen wishes to serve additional hours please consult with the Teenage Volunteer Coordinator.
   _____ Parent's Initials

6. In general, the Teenage Volunteer Program is only available during the summer months. However, teens may continue to volunteer during the school year if the assignment(s) is requested to, and approved by the Teenage Volunteer Coordinator following the teen's initial volunteer service. **_____ Parent's Initials**

____________________________	______________________________________	____________________
Name of Parent/Legal Guardian	Signature of Parent/Legal Guardian	Date

TUBERCULIN SKIN TEST PERMISSION SLIP

______________________________________will be required to have a tuberculin Skin Test (PPD) as part of his/her UF Health Central Florida School Internship or Volunteer requirements.

Tuberculosis is a communicable disease, transmitted through airborne droplets from an infected person. All healthcare facilities and many other public service industries are required by law to test their employees on a regular basis. The skin test, known as a PPD (purified protein derivative) is performed by placing an intradermal injection on the forearm. The small bubble or wheal will disappear. Keep the area clean and dry. Redness or bruising at the site may occur, but a red, raised or blistered area may indicate a positive reaction. A positive reaction does NOT indicate active disease, only that an exposure to tuberculosis has occurred at some point. If a positive reaction is confirmed a chest x-ray will be performed to determine the presence or absence of active disease. The team member health nurse will provide guidance as needed to arrange appropriate follow up.

Has your child:

1. Had a TB test (Mantoux) within the last 12 months? ❑ Yes ❑ No
2. Lived outside the United States? ❑ Yes ❑ No
3. Had a BCG vaccine? ❑ Yes ❑ No
4. Had a past positive reaction to a TB skin test? ***(If yes, complete reverse side)*** ☐ Yes ☐ No

*****Anyone with a history of a positive reaction must submit a negative chest x-ray taken within the last six months**

CONSENT: My child, _______________, is not suffering from unexplained weight lost, loss of appetite, night sweats, fatigue, chills and fever, blood in urine, chest pain or a prolonged cough. Is not taking drugs or medications which lower their immunity, nor do they have a disease which lowers immunity. They have not had any recent vaccinations.

I, _______________________________________, have read the information on tuberculosis and give my permission for this test to be performed including ppd injection and possible chest x-ray.

____ __________________

Signature **Date**

__________________________ __________________ __________________

_________________________ _________________________ _________________________

Relationship to Student **Home Phone** **Cell Phone**

FOR OFFICE USE ONLY

5TU (.1ml) of Tuberculin Purified Protein Derivative Intradermal

IF QUESTIONABLE OR>5MM INDURATION, MUST BE SEEN BY TEAM MEMBER HEALTH NURSE.

	1st Step	2nd Step
Date		
Forearm	L / R	L / R
Lot #		
Expiration Date		
Signature		
Date Read		
Reading	mm	mm
Signature		

TB SCREEN FOR THOSE WITH A HISTORY OF POSITIVE PPD

Do you have any of the following?

1. Chronic Cough ❑ Yes ❑ No with Sputum, color of Sputum: ___________
2. Persistent Night Sweats ❑ Yes ❑ No
3. Involuntary Weight Loss ❑ Yes ❑ No
4. Chronic Fatigue ❑ Yes ❑ No
5. Any serious Illness ❑ Yes ❑ No

If you answered YES to any of the above, please explain: ________________________________

____

Parent/Teen Signature: _____________________________ Date: ______________

Chest X-ray ordered: Yes: ______ No: ______

Date Ordered:_____________ Date Completed:____________ Results to parent: ____________

Results: ____

_____________________________________ _________________________

Team Member Health Nurse Signature Date

ANNUAL VOLUNTEER REQUIREMENTS

NAME OF VOLUNTEER: ______________________ DOB: ________ SSN: ______________

HOME/CELL PHONE: _______________________ OTHER PHONE: ___________________

1. Annual Training Module, HIPPA Training, Corporate Compliance Training and Annual TB

   Surveillance Forms_____________ __________ ________________________________
   Confirmation# Date Signature of Auxiliary Tester

2. Annual Vision Exam (For Drivers Only)

   _________ _________________________________
   Date Signature of Employee Health Nurse

NEW VOLUNTEERS REQUIREMENTS ONLY

1. HIPPA Training and Corporate Compliance Training completed

   ________ ___________________________________
   Date Signature of Auxiliary Tester

2. Orientation completed ________ ___________________________________
   Date Signature of Auxiliary Records Coordinator

EMPLOYEE HEALTH/HR REQUIREMENTS

1. 1st TB Test completed ________ ____________________________________
   Date Signature of Employee Health Nurse

2. 2nd TB Test completed _______ _____________________________________
   Date Signature of Employee Health Nurse

3. Vision Exam (For Drivers Only) _______ _____________________________________
   Date Signature of Employee Health Nurse

4. Released to volunteer by Employee Health

   ________ ___________________________________
   Date Signature of Employee Health Nurse

LRMC Employee Health
550 E. Dixie Dr.
Leesburg, FL 34748
(352) 323-4117
Fax (352) 323-4189