UF Health
THE VILLAGES® HOSPITAL

1451 El Camino Real, The Villages, FL 32159 | Phone 352.751.8176 | Please return completed application to the hospital front desk or fax to 352.751.8662.

TEENAGE VOLUNTEER APPLICATION FORM

This application is for Volunteer Placement Office (VPO) purposes only and is not valid until received and reviewed by the VPO. UF Health Central Florida is committed to providing a safe and healthy environment for everyone on campus. Prior to new volunteer orientation and assignment, applicants must pass all applicable background screenings.

Application Date:	
Last Name (please print): **First** **Middle**	
Present Address: **Street** **City** **State** **Zip**	
Cell Phone: **Home Phone:** **E-mail address:** **Best way to contact:** ☐ Text ☐ E-mail ☐ Cell phone	
Date of Birth: **Age:** **Female** **Male**	
Name Parent or Guardian who signed Permission to Volunteer form on page 4: **Cell phone:** **E-mail address:** **Best way to contact:** ☐ Text ☐ E-mail ☐ Cell phone	
Family Members working at UF Health? ☐**Yes** ☐**No** ☐**Previously, but they left on**	
EMERGENCY CONTACT	
Name:_____ **Relationship:**_____ **Home Phone:**_____ **Cell Phone:** _____	

VOLUNTEER EXPERIENCE

How did you hear about the Auxiliary volunteer program with UF Health The Villages® Hospital and UF Health Central Florida?

_____

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

Please return the following documents:

1. **Completed and signed application**
2. **Code of Ethics for UF Health The Villages® Hospital volunteers**
3. **Parental Permission form completed and signed by parent/guardian**
4. **Tuberculosis Permission form completed and signed by parent/guardian and volunteer**
5. **New Volunteer Registration form**
6. **Photography Consent form completed and signed by parent/guardian and volunteer**
7. **Additional Considerations form completed and signed by parent/guardian and volunteer**
8. **Two letters of personal references**

Signature:_____ **Date:**_____

FOR OFFICE USE ONLY

Application Received:_____**Interview Date:**_____**Interviewed By:** _____

Scheduled Orientation Date:_____**Start Date:** _____

Assignment: _____

Comments:_____

CODE OF ETHICS FOR UF HEALTH THE VILLAGES® HOSPITAL VOLUNTEERS

If accepted as a hospital volunteer, I agree to:

- Abide by the Standards and Expectations as outlined in the UF Health The Villages® Hospital (hospital) Auxiliary Membership Handbook and all approved amendments.
- Hold as absolutely confidential all information that I may obtain directly or indirectly concerning patients, guests, staff, other volunteers and all matters pertaining to the hospital.
- Work without contemplation of compensation or expectation of future employment.
- Be at all times punctual, conscientious, dignified, courteous and considerate of others while demonstrating tolerance and respect for all persons.
- Wear an approved uniform in the prescribed manner and maintain a professional appearance.
- Work according to the departmental standards, assume certain responsibilities, be accountable for what I do and refer questions beyond the scope of my position to the appropriate authority.
- Recognize that I am part of a team and be willing to help develop good teamwork both within the Auxiliary and other departments throughout the hospital.
- Anticipate being assigned to a service area which meets my needs, assists with the needs of the hospital, is enjoyable to me and attend orientation and training in the services I will provide.
- Adhere to the Auxiliary procedures for signing in and obtaining a substitute when I am unable to report for duty.
- Observe all present and subsequently issued Auxiliary policies and procedures. I understand that the hospital may revise its policies and procedures at any time.
- Adhere to the policy of tobacco/smoke free campuses.
- Complete a separate application if I wish to volunteer my time with the Auxiliary organization of any UF Health hospital.

I understand that the Auxiliary reserves the right to terminate my volunteer status as a result of 1) failure to comply with policies and procedures; 2) absences without prior notification; 3) unsatisfactory attitude, work appearance; or 4) any other circumstances which, in the judgment of the Volunteer Coordinator, would make my continued service as a volunteer contrary to the best interests of the hospital and its patients.

I consent to 1) any pre-volunteer testing/screening and 2) annual health testing and training required by the hospital. I further give permission to investigate any and all information concerning my application in order to determine my qualifications. This includes but is not limited to: medical clearance, criminal background checks, employment and personal reference checks.

In the event of my resignation or termination, I agree to return the identification badge issued to me.

Signature of Applicant: _____

Date: _____

PARENTAL PERMISSION TO VOLUNTEER

I hereby agree to allow my son/daughter _____ to serve as a Teen Volunteer with UF Health The Villages® Hospital (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 and defend the hospital, the Auxiliary, its officers, directors, employees and representatives from any and all liabilities and claims resulting solely from or attributable to acts or 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 your 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, they 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, therefore, your son/daughter will be removed as a volunteer. _____ **Parent's initials**

3. Your son/daughter shall provide the following required documents or cooperate with the hospital to obtain these documents prior to start or while volunteering:

    a. Application form
    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 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 and approved by the Teenage Volunteer Coordinator following the teen's initial volunteer service. _____ **Parent's initials**

Name of Parent/Legal Guardian: _____

Signature: _____ Date: _____

UFHealth
UNIVERSITY OF FLORIDA HEALTH

Annual TB/ Latex Surveillance - Volunteers

Print Name: _____DOB: _____ Date: _____

QuantiFERON Gold is a blood test that helps in the detection of mycobacterium tuberculosis which is responsible for causing TB. This is being used as an alternative to the tuberculin skin test. The QuatntiFERON Gold is also more specific and sensitive than the tuberculin skin test.

Within the last year, have you developed any difficulties with latex products? _____

If yes, what type of problem? _____

Have you had a positive reaction to a TB Test? ☐ Yes ☐ No

If yes, when was your last chest x-ray? _____ (if >5 years, EH nurse will order a new chest x-ray)

Have you been to the health department? _____
Have you been treated? _____ Where? _____ When? _____
Do you want treatment? _____

Do you have any of the following?

	Yes	No
Chronic Cough		
Persistent Night Sweats		
Involuntary Weight Loss		
Chronic Fatigue		
Any Serious Illness		
Chest Pain		
Blood in Urine		

If you answered yes to any of the above, please explain: _____

The Genetic Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting, or requiring, genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

CONSENT: I am not suffering from unexplained weight loss, loss of appetite, night sweats, fatigue, chills and fever, blood in urine, chest pain or a prolonged cough. I am not taking drugs or medication which lower my immunity, nor do I have a disease which lowers immunity. I have not had any recent vaccinations. I am not pregnant. I have read the above and consent to this test. If applicable have a chest x-ray completed.

Signature: _____ **Date:** _____

(Required for Minors)
Parent/Guardian Signature: _____ **Date:** _____

Parent/Guardian Name (Print): _____

Employee Health Department Use Only

Chest x-ray ordered ☐ Yes ☐ No Referred to Health Department ☐ Yes ☐ No

Date ordered: _____ Date completed: _____ Results: _____

New Volunteer Registration

Name: (please print legibly) _____ Date: _____

Mailing Address:

Street _____ City _____

State _____ Zip _____

Home phone: _____ Cell phone: _____

Date of birth: _____ Social Security Number: ____/____/____

Location where you will volunteer: UF Health The Villages® Hospital

Department where you will volunteer: Student volunteer program (various departments)

Do you have an allergy to latex? ☐ Yes ☐ No

If yes, please explain: _____

Auxiliary Photography Consent Form

I hereby grant permission to UF Health Central Florida to use, copyright and/or publish photographic portraits or pictures of myself and/or minor child listed below, made through any means for art, advertising, and/or trade purposes.

By signing below, I acknowledge that I have read and understand that I do not have the right to inspect or approve the finished product, the advertising copy that many be used in connection therewith, or the use to which it may be applied.

I agree not to use UF Health Central Florida, UF Health The Villages® Hospital or any other related service line name or logo in any type of endorsement or perceived endorsement without the written permission of the UF Health Central Florida Marketing & Public Relations Department.

Name of Auxilian/Volunteer: _____ Date: _____

Signature of Auxilian/Volunteer: _____

Name of Minor Child: _____ Date: _____

Signature of Parent or Guardian: _____

Witness: _____

Additional Considerations for Parents, Guardians and Students

Please consider the following:

We ask for a 4-hour commitment each week. Our volunteer opportunities are available in three 4-hour shifts each day, seven days a week.

To help us place you in a job that will make it easier for you to commit to the 4 hours per week, please circle the days and times that would fit your schedule the best:

Sunday	8 am to 12 noon	12 noon to 4 pm	4 pm to 8 pm
Monday	8 am to 12 noon	12 noon to 4 pm	4 pm to 8 pm
Tuesday	8 am to 12 noon	12 noon to 4 pm	4 pm to 8 pm
Wednesday	8 am to 12 noon	12 noon to 4 pm	4 pm to 8 pm
Thursday	8 am to 12 noon	12 noon to 4 pm	4 pm to 8 pm
Friday	8 am to 12 noon	12 noon to 4 pm	4 pm to 8 pm
Saturday	8 am to 12 noon	12 noon to 4 pm	4 pm to 8 pm

Are there other siblings or friends who will need to work on the same day and time? If so, please provide their names in the space below.

The Auxiliary will make every effort to schedule you at a time that is convenient for you. Allowances can be made for an occasional week off due to important school or family events.

Name of school: _____

Expectation of the number of hours this summer _____ achieved by_____
date

We agree that the days and times described above are the best for us.

_____ _____

Parent/Guardian signature Student signature