April 19, 2010

Dear Applicant:

Thank you for your interest in the 2010 Elliot Health System VolunTEEN program. We look forward to providing you with a volunteer position that best meets your interests, needs and goals while supporting the mission of the Elliot Health System.

Based on the ratio of anticipated applicants to available positions, returning teens, (teens who were enrolled during the summer of 2009 and met program requirements) will be given first priority in placement. Please carefully consider the requirements and expectations of the program before submission of your application. It is possible given the large pool of applicants that we will be unable to place all teens.

You will find the information about the 2010 VolunTEEN program and the required application, consent form, school recommendation forms and necessary medical history and Mantoux test questionnaire/consent form online.

The application, consent form, school recommendations and medical forms must be returned to the Elliot Hospital Volunteer Resource Department by Friday, May 21st, 2010.

Once your completed application packet is returned to the Volunteer Resource Department, one additional form, *the request for a youth employment certificate or the Parental Permission form*, will be mailed to you for completion. Once your application is received in our office, and your age is determined, the correct form will be sent to you. If you are 14 or 15 years old, you will be required to take *the request for a youth employment certificate* to your school to obtain a youth employment certificate ("working papers"). If you are 16 or 17 years old, you will need to obtain only your parent or guardian's signature on the Parental Permission form.

The Youth Employment Certificate you receive from your school ("working papers") or the parental permission form must be returned to the Elliot Hospital Volunteer Resource Department by June 18th, 2010.

We are very proud of the hundreds of volunteers of all ages who provide time, talent and that "special touch" for the patients, visitors, staff and physicians of Elliot Health System. Our volunteers are truly partners in caring.

If you have any questions, please do not hesitate to call the Volunteer Resource Department at The Elliot at 663-2298 or send an e-mail to: volunteer@elliothospital.org

We look forward to having you join us!

Sincerely,

Donna J. Wright
Director, Volunteer Resources

TO COMPLETE:

PLEASE PRINT ALL 14 PAGES INCLUDING THE COVER LETTER, APPLICATION AND THE OTHER REQUIRED FORMS

VOLUNTEER RESOURCES DEPARTMENT

Elliot Hospital, One Elliot Way, Manchester, NH 03103

Phone: 663-2298 Fax 663-2759

Email: volunteer@elliothospital.org

COMPLETED FORMS MAY BE DROPPED OFF AT THE ELLIOT HOSPITAL VOLUNTEER RESOURCES DEPARMENT, MAILED IN OR FAXED.

SUMMER 2010 APPLICATION FOR VOLUNTEEN SERVICE

Print Your Name: ____

ARE YOU A NEW OR RETURNING (from 2009) TEEN?

PLEASE CHECK ONE: NEW _______ RETURNING _______

- **Please carefully consider all requirements and expectations prior to submission of your application.**
- **Completion of an application does not guarantee placement.**

Program Requirements:

1. Applicants must be at least 14 years of age and have successfully completed 8th grade by June 30th, 2010. *(Due to a limited number of placement opportunities available this summer (2010) the number of fourteen year olds accepted will be minimal)*
2. Completion of all required paperwork by the May 21st, 2010 deadline.
3. Satisfactory review of medical information by Elliot Hospital Employee Health Department.
4. Satisfactory completion of two-step TB testing on scheduled dates (for NEW Applicants only).
5. Completion of a satisfactory personal interview with the Director of Volunteer Resources and/or another hospital department's staff as needed. (*Teens must be prepared at their interviews to discuss any previous work or volunteering experience as well as articulate their own expectations of their volunteer experience at the Elliot. Parents are asked to refrain from accompany teens to their interviews to answer the interviewer's questions)*

6. VolunTEENs, new and returning, must attend the scheduled orientation on Friday, June 25th, 2010, 9am -4pm. No other orientation sessions will be offered.
7. VolunTEENs must be able and willing to serve, at a minimum, one four-hour shift per week for at least 7 weeks of the 9-week summer program. (June 27th – August 28th, 2010)
8. VolunTEENS completing a minimum of 30 hours of service during the 9-week summer session will receive a letter confirming the number of hours served. Those VolunTEENs completing less than 30 hours during the 9-week summer session will not receive a letter until they reach the 30 hour minimum requirement. This hour requirement may be met by continuing volunteer service throughout the school year.

Expectations:

VolunTEENs are expected to:

- be willing and able to serve independently.
- adhere to hospital confidentiality policy.
- be highly motivated and sincere in the desire to serve as a volunteer.
- abide by all rules governing volunteers.
- be neat in appearance and cleanliness and adhere to uniform requirements.
- Be willing and able to meet all the program requirements listed above.

PLEASE BE SURE YOU AND YOUR PARENT/GUARDIAN HAVE READ AND UNDERSTAND THE PROGRAM REQUIREMENTS AS DESCRIBED ON PAGE 1 AND 2 OF THIS APPLICATION.

I have read and understand the program requirements. I am willing and able to adhere to all the program requirements and expectations.

Signature of Teen:_______________________________________ DATE:________________

I have read and understand the program requirements and expectations as outlined on the first page of this application.

Signature of Parent/Guardian: ____________________________ DATE:________________

SUMMER 2010 APPLICATION
PLEASE PRINT

Name ____ ☐ Male ☐ Female

Address ____
Street City/Town State Zip Code

Home phone:____________________ Cell phone: __________________________

Email address: ____

Age:___________________________ Date of Birth_____________________ (for statistics)

High School Name and City: ____

POLO SHIRT SIZE: SMALL _______ MEDIUM_______ LARGE_______X-LARGE _______
(Adult sizes only available)

Name(s) of Parent(s) or Guardian ____

Work Telephone Number: Father/Guardian___ext._____Mother/Guardian ________ext.____

IN EMERGENCY NOTIFY (If different from parent/guardian)

Name ______________________________ Relationship__________________

Day Telephone________________________ Evening Telephone _____________

Referred by friend/volunteer/employee or other? _____________________________

If you were referred, Name ____

Transportation: Car ________________Public Transportation ______________Walk ______
_____

Career Plans	
Paid Work or Volunteer Experience	
School/other activities	

SUMMER 2010 APPLICATION

In your own words, <u>on a separate sheet of paper</u>, please tell us why you want to volunteer with the Elliot Hospital? What do you hope to gain from this volunteer experience? How will volunteering at the Elliot assist you in obtaining your goals?

PLEASE INDICATE YOUR AREA OF INTEREST BELOW: (Please check **at least** one area) Every effort will be made to match you to your particular interest. Keep in mind: This is a just a sample of typical duties of a VolunTEEN)

If you are interested in volunteering in a hospital department where you can utilize and improve your office and clerical skills (such as alphabetizing, copying, calculations, assembling charts and packets of information, telephoning, filing, reception, and typing)
PLEASE CHECK THIS BOX ☐

If you are interested in volunteering in a hospital department where you can utilize a computer entering data, assisting in the preparation of reports
PLEASE CHECK THIS BOX ☐

If you are interested in volunteering in a hospital department where you can provide services to patients, visitors and staff, for example: escorting families, visitors, stocking linens, relaying messages from waiting rooms, assisting staff with errands
PLEASE CHECK THIS BOX ☐

If you are interested in volunteering in a hospital department where you can assist with the distribution of medical or office supplies to user departments or delivering mail to departments
PLEASE CHECK THIS BOX ☐

If you are interested in volunteering in the Adult Day Program interacting with older adults in an intergenerational experience
PLEASE CHECK THIS BOX ☐

If you are interested in becoming a “Patient Striper” providing services such as: readying a room for new patient admissions, escorting patients in wheelchairs, distributing fresh water and ice to patients, visiting with patients, playing cards or board games, answering call lights and relaying requests and messages to nurse, running errands for staff, greeting and directing visitors on the unit, assisting visitors in waiting areas, preparing and distributing extra nourishment and snacks as directed by nurse, making unoccupied beds, replacing bedside litterbags, tidying up the unit, assisting the staff with special projects, stocking charts and much, much more…
PLEASE CHECK THIS BOX ☐

If you are interested in volunteering at the Elliot Child Care Center (located near the hospital just off Massabesic Street) or the VNA Child Care and Family Resource Center (located at 435 S. Main Street) helping and interacting with children (ages infant –kindergarten)
PLEASE CHECK THIS BOX ☐
Do you have a location preference? If yes, circle your preference below:
Elliot Child Care Center or VNA Child Care Center

Please indicate other interests or departments not mentioned above________________________
____
____

SUMMER 2010 APPLICATION

Be advised that some departments of the hospital where teens may be placed are located off-site or in other buildings on the campus other than the hospital building. For example, Outpatient Rehab Services, Senior Health Center, Adult Day Care at Holt Ave., Elliot Child Day Care, VNA Child Day Care on S. Main St., Elliot Medical Center at Londonderry and the Facilities Grounds Maintenance.

What days of the week will you be available to volunteer this summer?

WEEK DAYS ☐ WEEKENDS☐

What hours will you be available to volunteer this summer?

MORNINGS ☐ AFTERNOONS ☐ EARLY EVENING ☐
(Note: Your actual volunteering schedule will vary according to your availability and the needs of each department.)

NH Youth Employment Law (RSA 276-A) is applicable to VolunTEENS – this may affect the total number of hours you are permitted to volunteer per day and per week.

VolunTEEN Program acceptance is contingent upon:

1. ***Completion of all required paperwork by the stated deadline.***
2. ***Satisfactory school recommendations.***
3. ***Satisfactory review of medical information by Elliot Hospital Employee Health Department.***
4. ***Satisfactory completion of two-step TB testing on scheduled dates (For NEW Applicants only)***
5. ***Completion of a satisfactory personal interview with the Director of Volunteer Resources and/or another hospital department's staff as needed.***
6. ***Attendance at scheduled orientation.***

I understand that Elliot Hospital is not obligated to provide placement, nor am I obligated to accept the position offered. To the best of my knowledge the information provided in my application is true and complete. I understand that any misrepresentations or omissions of facts shall be considered sufficient cause for dismissal.

________________________________	________________________________
Signature of Applicant	Date
________________________________	________________________________
Signature of Parent/Guardian	Date

Please complete and return no later than May 21st, 2010 to:

Elliot Hospital
Volunteer Resources Department
One Elliot Way
Manchester, NH 03103

CONSENT FOR MINOR TO PARTICIPATE IN THE 2010 VOLUNTEEN PROGRAM

This will authorize ____
PRINT NAME OF TEEN APPLICANT

date of birth __/___/___, a minor (under 18yrs old), to participate in the Elliot Hospital VolunTEEN Program. I understand that my son's/ daughter's services are donated to the Elliot Hospital without contemplation of compensation or future employment, and given for humanitarian, religious or charitable reasons.

I release the Elliot Hospital and its employees and agents from any claims or liability for any losses resulting from injury or illness to said minor during his/her participation as a VolunTEEN, unless such loss resulted from willful or grossly negligent conduct on the part of the Elliot Hospital. I also release the Elliot Hospital and its employees and agents from any and all claims related to the loss of any personal property that my child has brought with him/her to the Hospital during his/her participation as a VolunTEEN.

For treatment of minor injuries/illnesses incurred while volunteering at the Elliot I authorize the Elliot Hospital Employee Health Nurses to act as our agents. In case of an emergency, I authorize the Emergency Room Physicians as our agents to consent to X-ray examination, anesthetic, medical or surgical treatment and hospital care which is deemed advisable by the aforementioned physician in the exercise his of best medical judgment.

This authorization is given pursuant to the Policy and Procedures of the Elliot Hospital and shall remain effective for the period of time my son or daughter is a volunteer in the Elliot Hospital VolunTEEN Program.

____
Signature of parent(s) or guardian

Relationship to Minor ________________________________Date ______________

My child's physician is: Name:____

Physician's Phone#: ____

ELLIOT HOSPITAL VolunTEENS 2010
LIST OF IMPORTANT DATES

INTERVIEW DATES

You will be contacted after Friday, May 28th, 2010 by a department supervisor to schedule an interview for a VolunTEEN position.

ORIENTATION DATE

VolunTEEN Orientation will take place on Friday, June 25th, 2010, 9:00am – 4:00pm in the Elliot Hospital Conference Center (Ground level).

No other orientation sessions will be offered.

All VolunTEENs, new and returning, who will be serving as "Patient Stripers" on any of the patient care floors will also be required to complete the additional training which will be scheduled directly with the patient care supervisor as needed.

HEALTH SCREENING PROCESS

As part of the health screening process all **NEW** Applicants will receive **TWO** Mantoux Tuberculosis (TB) tests and readings. (You are considered **NEW** if you did not volunteer last summer -2009)

All TB testing and readings will be conducted at the Elliot Health System Employee Health Office, located at 30 CANTON STREET - SUITE 4, in Manchester. Phone: 663-2617

Directions to Employee Health from Downtown Manchester: From Elm Street, take Valley Street east. Take a left onto Tarrytown Road. At the first set of lights at the intersection of Auburn Street and Tarrytown Road take a left. Take a right into the **SECOND** parking lot at 30 Canton Street after the Cypress Medical Park sign. Proceed to the end of the parking lot and Employee Health is in Suite 4 on the right side.

FIRST TB TEST	**TUESDAY, JUNE 8th 7:00 AM - 4:45 PM**
FIRST TB READING	**THURSDAY, JUNE 10th 7:00 AM – 4:45 PM**
SECOND TB TEST	**TUESDAY, JUNE 15TH 7:00 AM – 4:45 PM**
SECOND TB READING	**THURSDAY, JUNE 17TH 7:00 AM – 4:45 PM**

All TB testing and readings will be conducted at the Elliot Health System Employee Health Office, located at 30 CANTON STREET - SUITE 4, in Manchester. Phone: 663-2617

ELLIOT HOSPITAL VOLUNTEER RESOURCES

SCHOOL RECOMMENDATIONS

The applicant is responsible for ensuring that **TWO** completed school recommendation forms are returned to the Elliot Hospital Volunteer Office by ***Friday, May 21, 2010.***

A coach, guidance counselor, principal or teacher should complete the school recommendation form and return it directly to the Volunteer Office at: Elliot Hospital at Elliot Hospital, Volunteer Resources Department, One Elliot Way, Manchester, NH 03103 or fax the form to the office at 663-2759. The school recommendation forms are included in this volunteer application packet.

The applicant, being considered for a volunteer position at Elliot Hospital, agrees by his/her signature on the application, that a representative of Elliot Hospital and a person who completes a school recommendation form for this applicant may exchange information regarding the applicant's qualifications without incurring any liability. Opportunities for all volunteers are provided without regard to religion, creed, race, national origin, age or sex.

ELLIOT HOSPITAL VOLUNTEER RESOURCES
CONFIDENTIAL REQUEST FOR
SCHOOL RECOMMENDATION

2010 VOLUNTEEN APPLICANT

To Whom it May Concern:

Each student who applies for volunteer work must have two recommendations from a coach, guidance counselor, principal or teacher. We would appreciate your evaluation and comments to help us choose candidates who will best benefit from our program and serve our organization and the recipients of our services. This information will be kept confidential. Please return the completed form to: Elliot Hospital, Volunteer Resources Department, One Elliot Way, Manchester, NH 03103 or fax the form to 663-2759 at your earliest convenience. Forms must be received by deadline. Thank you for your assistance.

Donna J. Wright
Director of Volunteer Resources
dwright@elliot-hs.org

MAIL/FAX DEADLINE: FRIDAY, May 21, 2010

STUDENT'S NAME: ______________________________

Please indicate your rating of the student's attributes:

	EXCELLENT	GOOD	AVERAGE	BELOW AVERAGE
Ability to learn new skills				
Ability to work independently				
Ability to work with others				
Accepts direction/supervision				
Attendance				
Courtesy				
Dependability				
Independent judgment				
Initiative				
Scholastic Record				

COMMENTS: ______________________________

____

____

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____

SIGNATURE: ______________________________ DATE: ______________

SCHOOL: ______________________________

TELEPHONE: ______________________________

EMAIL: ______________________________

ELLIOT HOSPITAL VOLUNTEER RESOURCES
CONFIDENTIAL REQUEST FOR
SCHOOL RECOMMENDATION

2010 VOLUNTEEN APPLICANT

To Whom it May Concern:

Each student who applies for volunteer work must have two recommendations from a coach, guidance counselor, principal or teacher. We would appreciate your evaluation and comments to help us choose candidates who will best benefit from our program and serve our organization and the recipients of our services. This information will be kept confidential. Please return the completed form to: Elliot Hospital, Volunteer Resources Department, One Elliot Way, Manchester, NH 03103 or fax to 663-2759 at your earliest convenience. Forms must be received by deadline. Thank you for your assistance.

Donna J. Wright
Director of Volunteer Resources
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Please indicate your rating of the student's attributes:

	EXCELLENT	GOOD	AVERAGE	BELOW AVERAGE
Ability to learn new skills				
Ability to work independently				
Ability to work with others				
Accepts direction/supervision				
Attendance				
Courtesy				
Dependability				
Independent judgment				
Initiative				
Scholastic Record				

COMMENTS: ______________________________

____

____

____

____

____

____

SIGNATURE: ______________________________ DATE: ______________

SCHOOL: ______________________________

TELEPHONE: ______________________________

EMAIL: ______________________________

ELLIOT HEALTH SYSTEM EMPLOYEE HEALTH
NEW TEEN VOLUNTEER MEDICAL HISTORY

VolunTEEN Name: ______________________________

Date of birth: ______________**Home telephone number:** ______________

PERSON TO CONTACT IN CASE OF EMERGENCY:
Name ______________________________Telephone______________

ALLERGIES (Including medications)______________________________
____
____
____

DO YOU HAVE ASENSITIVITY TO LATEX? ( ) NO ( ) YES
If "yes" describe testing and limitations:______________________________
____

PAST MEDICAL HISTORY:
Have you ever had the following? (Circle "NO" or "YES", leave blank if uncertain.)

Asthma	No	Yes
Epilepsy	No	Yes
Heart Disease	No	Yes
Tuberculosis	No	Yes
Anemia	No	Yes
Diabetes	No	Yes
Hepatitis	No	Yes
Hives or Eczema	No	Yes
Back Trouble	No	Yes
Any other heath issues?	No	Yes

If "Yes" to any of the above please explain: ______________________________
____
____

Are you taking any medication? _____ No ______Yes If "Yes", please list: ___________
____
____
_____

IMMUNIZATION HISTORY:
Measles or MMR (Rubeola):date of first dose ____________ date of second dose __________
*Must have two doses of measles vaccine
Mumps: date: ______________________________
German measles (Rubella) date:______________________
Have you ever had Chicken Pox (circle) YES NO
Date of last DPT or Tetanus Booster: ___________________

I hereby certify that all the questions in this medical questionnaire have been answered honestly and completely to the best of my knowledge.

Signature of parent/guardian: ______________________________ Date:

ELLIOT HEALTH SYSTEM EMPLOYEE HEALTH
RETURNING TEEN VOLUNTEER MEDICAL HISTORY

VolunTEEN Name: ______________________________

Date of birth: ______________ **Home telephone number:** ______________________

PERSON TO CONTACT IN CASE OF EMERGENCY:

Name ______________________________ Telephone ______________________

ALLERGIES (Including medications) ______________________________
____
____
____

Has there been any change in your medical health in the past year?
_____ No ______Yes **If "Yes", please list**: ______________________________
____
____
____

Are you taking any medication? _____ No ______Yes **If "Yes", please list:** ________
____
____

Have you had any additional immunizations this past year?

______NO _______YES

If "Yes", please list: ______________________________
____
____

I hereby certify that all the questions in this medical questionnaire have been answered honestly and completely to the best of my knowledge.

Signature of parent/guardian: ______________________________ Date: ____________

THIS FORM MUST BE COMPLETED FOR ALL **NEW** VOLUNTEENS

ELLIOT HEALTH SYSTEM

EMPLOYEE HEALTH SERVICE

MANTOUX TEST QUESTIONNAIRE AND CONSENT

1. Do you have any allergies? ☐ Yes ☐ No

   If yes, please list allergies: ____

   ____

2. Do you have a sensitivity or allergy to Latex? ☐ Yes ☐ No

3. Are you taking or have you taken any steroid medication in the last six weeks (ie: cortisone, medrol, prednisone)? ☐ Yes ☐ No

4. Have you ever had a Tuberculosis (TB) test before? ☐ Yes ☐ No

5. Have you ever had a Positive TB test or reacted to the TB test? ☐ Yes ☐ No

   If Yes, were you treated? ☐ Yes ☐ No
   Did you take any medication such as INH? ☐ Yes ☐ No

   Are you currently under a doctor's care for TB or being followed on medication because of a Positive reaction? ☐ Yes ☐ No
   If Yes, the name of the doctor is: ______________________________

   What was the method of testing used for your previous TB tests:

   _____ Tine Test (multi-prong stick)
   _____ Mantoux (single injection)
   _____ Don't remember

6. Have you ever received a BCG vaccination (BCG vaccine is a vaccine against TB)? ☐ Yes ☐ No

7. Within the last 4 – 6 weeks, have you received any immunizations (ie: for measles, mumps, MMR or Flu Vaccine)? ☐ Yes ☐ No

8. Have you ever received chemotherapy (cancer treatments) or been told you have an immune disorder? ☐ Yes ☐ No

9. Are you pregnant? ☐ Yes ☐ No

10: Where was your Place of Birth? _____ USA

   If Outside of the USA, what country? ______________________

   If your Place of Birth was Outside of the USA, how long have you lived in the USA? _______________

I GIVE MY CONSENT TO HAVE: ____tested for Tuberculosis by means of a Mantoux test.

PRINT VOLUNTEEN NAME

____ ___________________________

Parent/Legal Guardian Signature Date