PUTNAM
Community Medical Center
Making Our Communities Healthier
Volunteers

Putnam Community Medical Center
611 Zeagler Avenue
Palatka, FL 32177
(386) 326-8071
Fax (386) 328-3478
rose.bellamy@lpnt.net

Dear Prospective Volunteer:

Thank you for your interest in the Junior Volunteer Summer Program at Putnam Community Medical Center (PCMC). Teenage volunteers are an important part of our organization. Your presence and help provide comfort and support to the many patients and staff with whom you come in contact. As a volunteer, you will be certain of a satisfying and rewarding experience learning and working side-by-side with our dedicated staff. Please be advised that space is limited for this program and your applications will be scored.

The summer sessions will begin on Monday, July 6, 2015 and end on Friday, August 7, 2015. If you are accepted in the program, you will be required to attend Orientation on Monday July 6, 2015 from 9:30 AM to 2:00 PM in the AB conference room adjacent to the hospital lobby.

Students must meet the following criteria to be eligible for the program:

- Be between the ages of 16-18.
- Complete an application.
- Have a minimum of a 2.0 grade point average.
  You will need to provide a copy of your most recent report card with your application.
- Provide three recommendations, two from teachers and one from your guidance counselor.
- Complete a 2 step Tuberculosis (TB) skin testing *Provided by PCMC
- Complete a Successful drug screen *Provided by PCMC
- Pass a Level I Background screening *Provided by PCMC
- COMMIT TO WORK THE ENTIRE FIVE (5) WEEK PERIOD. (NO EXCEPTIONS)
- Provide a current immunization record.
- Be able to work a minimum of two days a week for 4 hours each.
- Purchase uniform shirt ($15.00) to be worn with khaki or black pants
  (No shorts, capris, or jeans). Closed toe shoes that are clean and in good repair.

If you meet these criteria and wish to be considered for the 2014 Summer Student Volunteer Program, please complete the attached application and return to the above mentioned address.

The deadline to enroll in the upcoming summer 2015 Session is Friday, May 29th by 2:00 pm.
No application will be accepted after this date.

Unfortunately, Putnam Community Medical Center does not accept court-ordered community service volunteers; nor will Volunteer Services verify volunteer hours for court-ordered community service.

Again, we appreciate your interest in volunteering at Putnam Community Medical Center. Our volunteers are a vital part of the caring spirit that thrives in our community. If you have any questions, please call me at (386) 326-8071.

Sincerely,

Rose A Bellamy

Volunteer Coordinator
Putnam Community Medical Center
rose.bellamy@lpnt.net

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PLEASE PRINT

APPLICATION FOR 2015 JUNIOR VOLUNTEER
SUMMER PROGRAM

Please read carefully, print clearly and answer all questions. Thank you!

PERSONAL/CONTACT INFORMATION:

Name: _____
Last First MI

Street Address: _____ Apt. #_____

City: _____ Zip Code: _____

_____ Home Phone: _____

_____ Cell Phone: _____

E-Mail: _____ Sex: Male _____ Female _____

Birth date: (00-00-0000) _____

When is best time to contact you? _____

What is your preferred method of contact? _____

IN CASE OF EMERGENCY, NOTIFY:

Parent/Legal Guardian: _____ Relationship: _____

Street Address (if different from above): _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____ Cell Phone: _____

Physician's Name: _____ Phone: _____

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WORK PREFERENCES:

Are you able to be on your feet for four hours: Yes No

When are you available to volunteer? (Must be a minimum of two days with a maximum of four days. Shifts are four hours in duration.)

Work Days:

Monday Tuesday Wednesday Thursday Friday Flexible

Work Shift: Mornings Afternoons Flexible

EDUCATION INFORMATION

School Attending: _____ Grade Level: _____

Guidance Counselor: _____ Phone: _____

Have you applied for the PCMC Jr. Volunteer Program prior to this application? _____

BACKGROUND INFORMATION

Have you ever been convicted of, had adjudication withheld, or pled guilty or nolo contendere (no contest) to a criminal offense (misdemeanor or felony)?
We do criminal background checks. Falsification or failure to disclose this or any other information on this application is ground for termination.
A conviction does not necessarily disqualify you from volunteer service).

Yes _____ No _____

If yes, please explain: _____

Have you ever been refused bond? Yes _____ No _____

If yes, please explain: _____

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SKILLS, ACTIVITIES AND WORK EXPERIENCE:

Special Skills and Talents: _____

_____

School Activities and Awards: _____

_____

Volunteer Experience: _____

Languages: _____

Why do you want to be a Putnam County Medical Center Volunteer? _____

_____

_____

Are you interested in the Medical Field? ☐ Yes ☐ No

Please number the following in order of your interest. (1 =very interested)

	Nursing		Emergency Department ED
	Obstetrics OB		Intensive Care Unit ICU
	Pharmacy		Laboratory
	Rehabilitation PT OT ST		Human Resources HR
	Respiratory Therapy RT		Administrative Assistant
	Radiology		Food Services
	Imaging		Physicians Services
	Supply Chain Management		Other (please write in)

Volunteers

STUDENT VOLUNTEER CONTRACT

IF ACCEPTED INTO THE PCMC JUNIOR VOLUNTEER SUMMER PROGRAM, I AGREE TO:

- Commit to work the entire Five (5) Week Period (July 6, 2015 until August 7, 2015.
- Attend Orientation and in-service training scheduled for Monday, July 6, 2015.
- I understand and am able to fulfill the requirement to work a minimum of 4 hours a week.
- Be punctual and notify my supervisor if unable to work as scheduled and find a substitute according to the volunteer substitution policy.
- Honor my commitment to a specific job assignment.
- I will hold all information as confidential concerning patients, families, staff members, physicians and volunteers.
- Become familiar with PCMC policies and procedures and uphold the Code of Excellence.
- Donate my services without contemplation of compensation or future employment.
- I will make my service professional in all ways. I will conduct myself with dignity, courtesy and have consideration for others.
- Purchase the appropriate volunteer uniform and maintain a well groomed appearance.
- **Carry out assignments in a professional manner and seek staff assistance when necessary.**
- **Discuss any problems, criticism or suggestions with my assigned supervisor.**
- Adhere to the PCMC Volunteer's sign-in procedure.
- I understand that the following may result in immediate dismissal: breach of confidentiality; lack of honesty; failure to complete work; personal attacks.
- **I will not make or receive personal phone calls (land line or cellular) while on duty unless it is for emergency purposes.**
- For privacy purposes I agree to not take or reproduce any photographs during my time at PCMC.
- I understand that only patients are to be seated and/or transported in the hospital wheelchairs.
- I understand that I must be in compliance with the dress code.

PARENT/GUARDIAN AGREEMENT

- Commit to work the entire Five (5) Week Period (July 6 2015 until August 7, 2015)
- I understand that Volunteer Services Department reserves the right to terminate my child's status as a result of (a) failure to comply with PCMC policies; (b) absences without prior notification; (c) unsatisfactory attitude, work or appearance, or (d) any other circumstances which, in the judgment of the department director, would make continued services as a volunteer contrary to the best interests of Putnam Community Medical Center and its patients.
- I give my consent for my son/daughter to submit this application to join the PCMC Junior Volunteer 2015 Summer Program.
- I give consent for PCMC to administer to my child a 2 step Tuberculosis (TB) skin test.

SIGNATURES:

_____ _____

Parent/Guardian Signature Student Applicant Signature

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STUDENT'S NAME:_____

TEACHER RECOMMENDATION:

I recommend the above named applicant to serve as a Putnam Community Medical Center Jr. Volunteer for the 2014 Summer Program. _____ Yes _____ No

Comments: His/her grade point average is a 2.0 or higher:_____

_____

Teachers Signature _____ Date: _____

Teachers Name (Please Print:_____ Position: _____

School: _____ Phone: _____

TEACHER RECOMMENDATION:

I recommend the above named applicant to serve as a Putnam Community Medical Center Jr. Volunteer for the 2014 Summer Program. _____ Yes _____ No

Comments: His/her grade point average is a 2.0 or higher:_____

_____

Teacher's Signature: _____ Date:_____

Teachers Name (Please Print): _____ Position: _____

School: _____ Phone: _____

GUIDANCE COUNSELOR RECOMMENDATION:

I recommend the above named applicant to serve as a Putnam Community Medical Center Jr. Volunteer for the 2014 Summer Program. _____ Yes _____ No

Comments: His/her grade point average is a 2.0 or higher:_____

_____

Counselor's Signature: _____ Date:_____

Counselors Name (Please Print): _____ Position: _____

School: _____ Phone: _____

PUTNAM COMMUNITY MEDICAL CENTER
JUNIOR VOLUNTEER PROGRAM
PARENTAL AUTHORIZATION/RELEASE FORM

Dear Parent:

Volunteering in a hospital setting has many potential benefits for teens. It teaches teamwork and responsibility and helps develop a work ethic and maturity while exposing the volunteer to various career fields within the healthcare environment.

However, the potential exists for your child to witness certain situations that require advanced levels of maturity. For example, volunteers may be present when a trauma patient is rushed into surgery or may even be present when a patient dies. A volunteer may come into contact with patients in various stages of agitation or anger, along with those who may have attempted suicide or committed acts of violence. Please be advised that the potential to witness varying degrees of nudity does exist.

In order to protect our patients and staff, the hospital requires a yearly PPD test for tuberculosis to be performed on all employees and volunteers, including Junior Volunteers. There is no charge for this service. The test will be given prior to assignment and your child must return two days later to be checked. This test is a requirement to be a Junior Volunteer.

I understand that my child may be exposed to circumstances such as those listed, but not limited to, the above. I also understand that my child will be provided in-service training similar to that received by adult volunteers regarding reducing the risk of exposure to blood and body fluids and other contagious diseases, and will also receive a PPD test. I hereby release Putnam Community Medical Center, its officers, staff, and volunteers from any liability, and I give permission for my child to be assigned as a Junior Volunteer within the hospital.

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

_____ _____

PARENT/GUARDIAN PRINTED NAME DATE

_____ _____

JUNIOR VOLUNTEER SIGNATURE DATE

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CONSENT FOR PHOTOGRAPHY, FILMING, INTERVIEWS, ADVERTISING AND/OR PUBLICITY

(*) If participant is a minor

PARTICIPANT'S NAME(S)

* PARENT / GUARDIAN NAME

MAILING ADDRESS

CITY / STATE-PRVC / ZIP-PC

DATE OF BIRTH

TELEPHONE NUMBER

TODAY'S DATE

ALTERNATE PHONE

I hereby consent, as a patient, employee, affiliate, vendor, volunteer, professional associate and/or friend of **Putnam Community Medical Center** to being photographed, filmed, recorded and/or interviewed. I hereby give my permission that these photographs, films, recordings and information may be used for radio, television, print, outdoor, website, promotional, electronic, photographic or other advertising, publicity, promotional, and/or educational campaigns, either directly by the medical centers or an advertising agency on their behalf. The hospital and parent company Life Point Hospitals Inc. own the rights for these purposes and I will not be compensated for any testimonial, publicity, education, advertising or related usage.

Signature of Participant

Signature of Witness

Signature of Parent / Guardian*

Volunteers

Drug and Alcohol Acknowledgement & Release Form

Putnam Community Medical Center has adopted a Drug and Alcohol Free Workplace Safety Policy applicable to all of its employees. A copy of this policy has been provided for your review.

By signing below, I certify that I have read and understand Putnam Community Medical Center's Drug and Alcohol Free Workplace Safety Policy and I further agree and consent to the taking of any blood or urinalysis tests required by Putnam Community Medical Center as part of a post offer employment physical or otherwise, and authorize the release of any tests results to Putnam Community Medical Center. If hired by Putnam Community Medical Center, I hereby give my consent to any drug or alcohol testing which may be required by the hospital and authorize the release of any test results to Putnam Community Medical Center. I further understand that based on this policy, in the event of a workplace accident, I will submit to a post accident drug screen. I understand that failure to complete this drug screen immediately after the accident will subject me to disciplinary action up to and including termination.

_____ _____

Signature Date

Parental Authorization:

I, _____, a parent or guardian of_____ (age 17 and under) do hereby voluntarily consent to the physical examination of said minor as described in this Drug Screening Consent Form. I have thoroughly read this form and I certify that I understand its content.

_____ _____

Parent/Guardian Signature Date

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Personal Information:

Name:_____ Date of Birth:_____SS#_____

Address:_____ Telephone No. _____

_____ Applicant Job Title: _____

Medical History:

1) Have you ever had any of the following conditions or diseases? **(Please circle one or the other)**

Anemia	Yes	No	Hernia	Yes	No
Cancer	Yes	No	Depression	Yes	No
Smallpox	Yes	No	Measles	Yes	No
Diabetes	Yes	No	Hepatitis	Yes	No
Diphtheria	Yes	No	Mumps	Yes	No
Epilepsy	Yes	No	Pleurisy	Yes	No
Heart Disease	Yes	No	Pneumonia	Yes	No
Kidney Trouble	Yes	No	Chicken Pox	Yes	No
Mononucleosis	Yes	No	Emphysema	Yes	No
Scarlet Fever	Yes	No	Tuberculosis	Yes	No
Typhoid Fever	Yes	No	Whooping Cough	Yes	No
Mental Disorder	Yes	No	Rheumatic Fever	Yes	No
Blood Pressure	Yes	No	Carpal Tunnel	Yes	No
Latex Allergies	Yes	No	Sight or Hearing Problems (including color blindness)	Yes	No

2) Have you had any of the following? If the answer is yes, please provide the date and a brief description of the occurrence.

Fractures: Yes No _____

_____

Back problems or injuries: Yes No _____

_____

Other Injuries that caused you to miss work more than 10 days: Yes No

_____

Surgeries: Yes No _____

_____

3) Has a physician ever given you permanent physical restrictions? Yes No

(if yes please list the restrictions and provide a copy of the doctors note outlining the restrictions)

_____

I have read the above and answered the questions fully and declare that I have no known injury, illness, or ailment other than those previously noted. I further understand that any misrepresentation or omission may be grounds for corrective action.

_____ _____

Applicant Signature Date

_____ _____

Information Obtained from Parent or Guardian Date

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MEDICAL HISTORY and AUTHORIZATION DATE: _____

As a potential Putnam Community Medical Center Junior Volunteer you will be required to complete a 2-step Tuberculosis (TB) skin test prior to being placed into a volunteer position. If you have a positive reaction to a TB skin test, you will be screened by our Employee Health nurse and given instructions if a follow up is necessary. The hospital will provide the TB skin test free of charge during a scheduled appointment.

VOLUNTEER NAME: _____ **AGE:** _____

MEDICAL HISTORY

List Any Restrictions of Applicant: _____
Last Tetanus/Toxoid Booster: _____ Allergies to Drugs/Food: _____
Pertinent Medical History and any Special Medications Taken: _____

TO PARENT:

If your child has epilepsy, diabetes, allergies, heart condition, etc., and/or is taking special medication for any condition, it is important that you advise us so that in the event of an emergency resulting from his/her illness, medical personnel can provide proper treatment. This information will at all times remain confidential, except where it affects his/her ability to receive medical attention.

List any Physical Limitations of Child: _____

AUTHORIZATION

I, we, the undersigned, parent(s)/legal guardian of _____ , a minor, do hereby authorize Employee Health Nurse or Designee as agents for the undersigned to consent to any Putnam Community Medical Center (1) pre-volunteer testing required (2 step Tuberculosis (TB) skin test (2) x- ray examination; (3) anesthetic; (4) medical or surgical diagnosis or treatment and hospital care which is deemed advisably by, and is to be rendered under the general or special supervision of any physician licensed under the provisions of the Medicine Practice Act on the medical staff of the above named hospital, when such diagnosis or treatment is rendered at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis or hospital care being required and is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment of hospital care which the aforementioned physicians, in the exercise of his best judgment, may deem advisable.

It is understood that the effort shall be made to contact the undersigned prior to rendering treatment to the patient, and that any of the above treatment will not be withheld if the undersigned cannot be reached.

SIGNATURE OF PARENT/LEGAL GUARDIAN: _____

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CONSUMER AUTHORIZATION

I. I understand that an investigative report may be generated on me that may include information as to my character, general reputation, personal characteristics, or mode of living; work habits, performance or experience, along with reasons for termination of past employment/professional license or credentials; financial/credit history; or criminal/civil/driving record history. I understand that General Information Services, Inc. (GIS), on behalf of LIFEPOINT HOSPITALS, INC may be requesting information from public and private sources about any of the information noted earlier in this paragraph in connection with LIFEPOINT HOSPITALS, INC. and its affiliates' consideration of me for employment, promotion or position re-assignment or contract now, or at any time during my tenure with LIFEPOINT HOSPITALS, INC. and its affiliates, and give my full consent for this information to be obtained.

II. IF APPLICABLE, medical and worker's compensation information will only be requested in compliance with the Federal Americans with Disabilities Act (ADA) and/or any other applicable state laws.

III. According to the **Fair Credit Reporting Act** (FCRA, Public Law 91-508, Title VI), I am entitled to know if the considerations for which I am applying are denied because of information obtained from a consumer reporting agency. If so, I will be notified and be given the name of the agency providing that report.

IV. I acknowledge that a telephonic facsimile (FAX) or photographic copy of this release shall be as valid as the original. This release is valid for most federal, state and county agencies.

V. I understand that if I am a resident of **Minnesota/Oklahoma (only)** I may obtain a copy of the report ordered, and now indicate my desire to do so by checking this box ☐.

VI. I hereby authorize, without reservation, any financial institution, law enforcement agency, information service bureau, school, employer or insurance company contacted by GIS to furnish the information described in Section I.

VII. Upon proper identification, you have the right to make a request to GIS, within a reasonable period of time, as to the nature and substance of all information in its files on you at the time of your request, including the sources of information and the recipients of any reports on you that GIS has previously furnished. Communications with GIS should be directed to PO Box 353, Chapin SC 29036 or (866) 265-4917.

CANDIDATE COMPLETE THE FOLLOWING:

_____ Signature

_____ Today's Date

_____ Please PRINT Full name

If under 18, Parent's Consent and Signature _____

The following information is required by law enforcement agencies and other entities for positive identification purposes when checking public records. It is confidential and will not be used for any other purposes.

_____ Month, Day and Year of Birth

_____ Social Security Number

_____ Home Address

_____ City _____ State _____ Zip

_____ Driver's License Number and State

_____ Name as it appears on License

_____ Gender (Male/Female

_____ Alternate Name(s) Used

_____ Professional License Held

_____ License Number and State Issued

Previous Addresses for the Last 7 Years (use additional page if needed)

_____ Street Address

_____ City _____ State _____ Zip

_____ Street Address

_____ City _____ State _____ Zip

Employment to cover up to 7 years (attach additional page if needed)

1. _____ **Employer Name**

_____ City, State

_____ Phone Number

_____ Dates: To / From

_____ Job Title

_____ Reason for Leaving

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2. _____ _____ _____
Employer Name City, State Phone Number

_____ _____ _____
Dates: To / From Job Title Reason for Leaving

3. _____ _____ _____
Employer Name City, State Phone Number

_____ _____ _____
Dates: To / From Job Title Reason for Leaving

Education (use additional page if needed)

_____ _____
Institute Name City, State

_____ Graduated? □ Yes □ No _____
Dates Attended Degree Earned

_____ _____
Institute Name City, State

_____ Graduated? □ Yes □ No _____
Dates Attended Degree Earned

Please provide three (3) Professional References

1. _____ _____ _____
Reference Name City, State Phone Number

2. _____ _____ _____
Reference Name City, State Phone Number

3. _____ _____ _____
Reference Name City, State Phone Number

Have you ever been convicted of a crime? __ No __ Yes If yes, please provide offense date, city and state of conviction and details of conviction.

_____

_____

FAIR CREDIT REPORTING ACT NOTICE:
In accordance with the Fair Credit Reporting Act (FCRA, Public Law 91-508, Title VI), this information may only be used to verify a statement(s) made by an individual in connection with legitimate business needs. The depth of information available varies from state to state . Status of updates are available on request. Although every effort has been made to assure accuracy, General Information Services, Inc. cannot act as guarantor of information accuracy or completeness. Final verification of an individual's identity and proper use of report contents are the user's responsibility. General Information Services, Inc.'s policy requires purchasers of these reports to have signed a Service Agreement. This assures General Information Services, Inc. that users are familiar with and will abide by their obligations, as stated in the **FCRA**, to the individuals named in these reports. If information contained in this report is responsible for the suspension or termination of an employee or the application process, have the Candidate/employee contact General Information Services, Inc.

NOTICE TO CALIFORNIA CANDIDATES

You have a right to obtain a copy of any consumer report or investigative consumer report obtained by LIFEPOINT HOSPITALS, INC by checking the box provided below. The report will be provided to you within three (3) business days after we receive the requested reports related to the matter investigated.

□ I request to receive a free copy of this report by checking this box.

Under section 1786.22 of the California Civil Code, you may view the file maintained on you by GIS during normal business hours. You may also obtain a copy of this file upon submitting proper identification and paying the costs of duplication services, by appearing at GIS in person or by mail. You may also receive a summary of the file by telephone. The agency is required to have personnel available to explain your file to you and the agency must explain to you any coded information appearing in your file. If you appear in person, a person of your choice may accompany you, provided that this person furnishes proper identification.

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Please be advised that it is imperative that you read the cover sheet in its entirety and supply all of the requested documents. Your application will be scored on a variety of areas not limited to, but to include; content, neatness, background, and your timely response to any and all correspondence. You need to view this like you are applying for a job and conduct yourself in a corresponding manner. Before submitting your application review your submission to ensure that you can achieve the best possible score.

When you submit your application you will need to submit your payment of $15.00 for your uniform shirt. Please be sure to have exact change, and if you are writing a check it will need to be made out to PCMC Volunteers, Inc. with a note on the "**For"** line stating Jr. Volunteer Summer Program. The uniform shirts are required and are a unisex scrub shirt. For the ladies this means that the sizes are closer to a man's size and you may want to order a smaller size.

Please return the below portion and attach it to the front of your application

---

Name: _____
First Last

Scrub Shirt Size (please circle)

Extra Small Small Medium Large Extra Large 2XL

Please sign on the space provided acknowledging that you have read and understand this document.

_____
Student signature Date