



Dear Junior Volunteer Applicant:

Thank you for your interest in the Junior Volunteer program at Lutheran Medical Center (LMC). Most volunteers serve a three to four hour shift a week. A variety of volunteer opportunities are available from clerical to serving our patients in various areas of the hospital. Volunteers must be at least 15 years of age and have a current Photo I.D. LMC **does not** offer short term volunteer opportunities; a six-month minimum commitment is expected. LMC does not accept court ordered community service assignments.

Volunteers are placed according to current openings as well as their availability, particular talents/skills and compatibility with the program. Weekend and evening opportunities can be limited.

To become a LMC Junior Volunteer, please complete the following steps, in order, as they are listed below:

- 1. Complete an application and return it to Volunteer Services (with a copy of your birth certificate and immunization record).**
- 2. Attend Orientation - Call 303-425-2142 to register for Orientation. At Orientation you will receive information regarding TB screening and drug testing (done free of charge at the hospital).**
- 3. Make an appointment for a placement interview.**

IMPORTANT INFORMATION: To comply with Colorado State law, all healthcare workers, including volunteers, are required to obtain an influenza vaccination or provide proof of vaccination. Vaccine will be offered free of charge at LMC. If vaccine is received elsewhere, a written statement from a licensed healthcare provider specifying that the vaccine was administered and the date it was administered will be required.

Scholarship opportunities are also available for LMC Junior Volunteers. Scholarships in the amount of \$500 to \$2,000 are awarded yearly. You may apply for one of these scholarships if you:

- Are an active volunteer (volunteering weekly) as of March 1st of your senior year.
- Have completed 300 volunteers hours at LMC by March 1st of your senior year.
- Continue to volunteer through high school graduation.

College scholarships are for freshman year only and are not renewable.

Please contact Volunteer Services (303-425-2142) with any questions. Thank you.

Sincerely,

Debbie Anderson

Debbie Anderson, Manager

Volunteer Services

APPLICATION FOR JUNIOR VOLUNTEER PROGRAM

An Equal Opportunity Employer. Lutheran Medical Center does not discriminate on the basis of race, religion, national origin, color, sex, age, veteran status, disability or any other status protected by law/regulation. It is our intention that all qualified applicants be given equal opportunity and that selection decisions are based on position-related factors

Date: _____ Birthdate: _____

Full Name: _____

Name you go by: _____

Street Address: _____

City, State, Zip Code: _____

Home Phone: _____ Cell Phone _____

E-Mail Address _____

Name of Mother/Guardian and daytime phone #: _____

Name of Father/Guardian and daytime phone #: _____

Education: Circle current year of school: 8 9 10 11 12 Year will you graduate _____

School you attend: _____

Special Training or Skills (Computer, etc.): _____

Previous Volunteer &/or Work Experience: _____

Other activities you're involved in: _____

Are you a participant in the Executive Internship Program? _____ Yes _____ No

] How did you hear about our Volunteer Program?

• **In Case Of Emergency, Please Notify** (name, home and work phone numbers):

Physician (name and phone number): _____

I, _____ attest that the above information is truthful to the best of my knowledge.
Signature of Applicant

REFERENCES

To help us get to know you better and identify the correct volunteer placement for you, we ask that you have three people you know complete the information below. References should be people you know through church, co-workers, supervisors or managers you have worked for, teachers, people you know through community activities...etc. People you name as references should be knowledgeable about the skills, experience and personal qualities that qualify you for volunteering at LMC. **Please return this form with your application.** Thank you!

APPLICANT'S NAME: _____

1. Name: _____ Phone Number: _____

How long have you known the applicant and in what capacity?

Explain why you think this applicant would make a good Junior Volunteer at Lutheran Medical Center:

2. Name: _____ Phone Number: _____

How long have you known the applicant and in what capacity?

Explain why you think this applicant would make a good Junior Volunteer at Lutheran Medical Center:

3. Name: _____ Phone Number _____

How long have you known the applicant and in what capacity?

Explain why you think this applicant would make a good Junior Volunteer at Lutheran Medical Center:

PARENTAL CONSENT FORM

I hereby authorize _____, a minor, (but at least 14 years old) to participate in such volunteer activities at Lutheran Medical Center (LMC) as from time to time may be prescribed by the hospital's Director of Volunteer Services or the Volunteer Services Manager. We understand that the services of a Junior Volunteer are donated to the hospital without contemplation of compensation or future employment, and given for humanitarian, religious or charitable reasons.

We release LMC and its employees from any claim of liability for any damages, injury or illness resulting to said minor, not occasioned by any fault or neglect on the part of the hospital, while participating in such volunteer activities.

In the event of a medical emergency, we understand that every effort will be made by the staff at LMC to contacts us. If we are unable to be reached, we hereby authorize the Emergency Room Physicians as our agents to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions set forth by the state of Colorado on the medical staff of the hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital. This authorization is given in advance of any specific diagnosis, treatment or hospital care being required but 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 or hospital care which the aforementioned physician in the exercise of his or her best judgment may deem advisable.

At LMC we are committed to the safety of our patients, volunteers, visitors and employees. In an attempt to insure safety, we conduct post-offer and for cause drug and/or alcohol testing. A clean drug/alcohol screen is expected of all volunteers before they can begin their volunteer assignment. Anyone with a confirmed positive drug screen will not be assigned and will not be able to re-apply for at least one year. Drug/alcohol test results are protected under the law and will be released only to the prospective volunteer being tested.

Junior Volunteers placed in patient care areas may experience certain clinical conditions including death/dying and trauma. There is also the possibility of exposure to blood, mucous and other body fluids.

Additionally, LMC requires all volunteers to receive an influenza vaccine or provide proof of vaccination. Vaccine will be offered at LMC free of charge. If vaccine is received elsewhere, a written statement from a licensed healthcare provider specifying that the vaccine was administered and the date it was administered will be required.

This authorization shall remain effective for the period of time my son/daughter is an LMC Junior Volunteer.

Signature of parent/guardian

Date

VOLUNTEER TB TESTING AND RESULTS
(Jr. Volunteer Parent Permission for TB Testing and Flu Vaccination)

Name (Last, First) please print

Phone Number

If under 18 – signature of parent or guardian is required.

I give my permission for _____ to receive the following:

_____ TB Testing

_____ Flu Vaccination (during the months of October – March)

Both of these are mandatory.

Signature of parent or
guardian _____

Date _____

Please answer a few questions before taking your PPD TB skin test. The purpose of these questions is to prevent adverse reactions to the test.

YES NO Have you ever had a POSITIVE TB skin test?

YES NO Have you ever been told not to take a TB test, because you are allergic to the products in the testing serum?

YES NO Do you have any illness, or are you taking any systemic steroids or other medication now, or in the last month which causes you to be susceptible to infection?

Signature of Volunteer

Date

#1 Date: _____

Drug: Tubersol

Site: Left Right Forearm

Manuf: SANOFI PASTEUR

Lot: _____

Exp. Date: _____

Signature: _____

#2 Date: _____

Drug: Tubersol

Site: Left Right Forearm

Manuf: SANOFI PASTEUR

Lot: _____

Exp. Date: _____

Signature: _____

#1 Date Read: _____

Results: _____ **MM**

Signature: _____

#2 Date Read: _____

Results: _____ **MM**

Signature: _____

POSITIVE RESULTS HX PAST POSITIVE

Chest x-ray on file? YES NO

Ordered _____ (date)

CX-R results: _____

Follow-up: _____