

ALHAMBRA HOSPITAL MEDICAL CENTER

Dear Prospective Volunteer,

Thank you for your interest in giving your time to volunteer at Alhambra Hospital Medical Center. All of our opportunities for high school and college students require a 40-hour minimum commitment. We have no short-term volunteer opportunities. We accept new student volunteers year round; however, the number of openings is limited, since many of our volunteers stay with us year after year.

- Age Requirements:
 - All students must be 15 years of age to begin volunteer service. To start the volunteer process, the following steps must be taken:
- Application:
 - Complete the attached Volunteer Application Form and return it to the Volunteer Services Department by mail to: Volunteer Services Dept., AHMC, 100 S. Raymond Ave., Alhambra, CA 91801, or bring it in person to our office, Monday through Friday, 9 am to 5 pm.
- Placement Interview:
 - Attend a scheduled interview with the Coordinator of Volunteer Services. Upon receipt of your application, a letter will be sent to you with your interview date and time.
- TB Mantoux Test:
 - If admitted to the program, a TB clearance is required for all volunteers. After the tuberculosis test is administered, you must be able to return to have it evaluated after 48 hours. This must be completed by the orientation date. You will be given paperwork to be tested (free) at AHMC, or you may provide your own TB test results if they were done within three months of your application submission.
- Orientation:
 - Attendance at an orientation is mandatory. All volunteers must complete a 1½ hour orientation prior to being assigned a position. A study packet will be given to you during your interview, so that you are informed of what will be discussed during this time.

Please Note: We make every attempt to place our applicants; however, in some cases, it is not possible due to unavailability of volunteer positions or other factors.

We would be happy to answer any questions you may have, so please call the Volunteer Services Department at (626) 458-4787. Office hours are 9:00 am to 5:00 pm, Monday through Friday. Thank you again for your interest in our volunteer program. We look forward to meeting you.

Sincerely,

Volunteer Services Department

ALHAMBRA HOSPITAL MEDICAL CENTER

VOLUNTEER APPLICATION

PLEASE PRINT AND COMPLETE:

Name: _____
(Last) (First) (Middle Initial)

Name Tag to Read: Male Female

Address: _____

City: _____ Zip Code: _____

Home Phone: _____ Social Security No.: _____

Bus./Cell Phone: _____ E-mail address: _____

Birthdate: _____ Age Group: 15-40 41-60 61+

College Graduation Year: _____ High School Graduation Year: _____

Current High School/College (if applicable): _____

Previous Volunteer Experience: _____

Emergency Contact Name: _____ Phone: _____

Volunteer Program Preference: Student Adult

May we contact you to assist with special projects such as Health Fairs and mailings?

Yes No

Available hours and days:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning							
Afternoon							
Evening							

In what areas are you most interested in volunteering?

- Patient Care Areas
 Guest Relations/Translation
 Clerical
 Pharmacy
 Physical Therapy
 Other

Languages in which you are fluent: _____

What are your hobbies or special interests? _____

How did you become interested in our Volunteer Program? _____

Local Personal Reference: _____
(Name) (Phone Number)

Do you have any physical limitations? _____

Physician: _____
(Name) (Phone Number)

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FOR OFFICE USE ONLY

Interviewed: _____ **Name Badge Ordered:** _____

Orientation Date: _____ **TBC Skin Test/Chest Film:** _____

Assignment: _____ **Uniform Payment:** _____

_____ **Uniform Issue:** _____

ALHAMBRA HOSPITAL MEDICAL CENTER

VOLUNTEER PROGRAM AGREEMENT

1. I will hold as absolutely confidential all information that I may obtain directly or indirectly concerning patients, physicians, or personnel, and not seek to obtain confidential information from a patient. I will follow the hospital's privacy policies and procedures on Protected Health Information (PHI) in accordance with the state and federal regulations. I understand failure to do so will be subject to termination of the volunteer position, and may lead to civil and criminal remedies.
2. My services are donated to the hospital without contemplation of compensation.
3. I will not sell or attempt to sell goods or services, or request contributions.
4. I will submit to examinations, which may include chest X-rays, appropriate laboratory tests and/or immunizations that may be necessary as part of my volunteer service. I hereby authorize my doctor(s) to furnish the hospital information concerning my health. I also authorize the person(s) making tests or X-ray films to report the results to the hospital.
5. I will be punctual and conscientious, conduct myself with dignity, courtesy, and consideration of others, and endeavor to make my work professional in quality.
6. I have received a copy of the volunteer responsibilities and will comply.
7. I will attempt to resolve any problems related to my volunteer activities with my supervisor, and if unsuccessful, attempt to resolve such problems with the Coordinator of Volunteer Services.
8. I will make my best effort to fulfill my commitment to the hospital by completing all assignments that I accept.
9. I will at all times uphold the philosophy and standards of the hospital.
10. I understand that the Coordinator of Volunteer Services reserves the right to terminate my volunteer status as a result of:
 - a. Failure to comply with hospital policies, rules, and regulations.
 - b. Absences without prior and proper notification.
 - c. Unsatisfactory attitude, work, or appearances.
 - d. Any other circumstances which, in the best judgment of the Volunteer Coordinator, would make my continued service as a volunteer contrary to the best interest of the hospital.

I have read each of the above conditions and I agree to be bound by them.

Volunteer Signature

Date

Volunteer Parent Signature (*if volunteer is under the age of 18*)

Date

WITNESS CLAUSE

I agree that I have explained each of the conditions of volunteer service to the applicant who has signed this form, and that I have witnessed the applicant's signature.

Volunteer Services Dept. Representative Signature

Date

ALHAMBRA HOSPITAL MEDICAL CENTER

CONSENT FOR MINOR TO PARTICIPATE IN VOLUNTEER ACTIVITIES

This will authorize _____, a minor, to participate in such volunteer activities at ALHAMBRA HOSPITAL MEDICAL CENTER as from time to time may be prescribed by the hospital's Volunteer Services Coordinator, or the designated representative. I understand that my daughter's or son's services are donated to the hospital without contemplation of compensation or future employment, and given for humanitarian, religious, or charitable reasons.

We release the hospital 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.

We 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 of the Medical Practice Act 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.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California, and shall remain effective for the period of time my son or daughter is a volunteer at the hospital.

Volunteer Signature

Date

Signature of parent/guardian *(if volunteer is under the age of 18)*

Date

ALHAMBRA HOSPITAL MEDICAL CENTER

VOLUNTEER HEALTH CLEARANCE AUTHORIZATION

NAME: _____

SOCIAL SECURITY #: _____

RADIOLOGY DEPARTMENT

Chest X-Ray

OCCUPATIONAL HEALTH

PPD (TB Skin Test).....

DATE: _____

TIME: _____

I hereby authorize Alhambra Hospital Medical Center to perform, or obtain information pertaining to, a PPD skin test and/or chest x-ray, as appropriate, as part of my acceptance into the volunteer program.

Volunteer Signature

Date

Parent/Guardian Signature *(if volunteer is under the age of 18)*

Date