Bayfront Health
Port Charlotte • Punta Gorda

TEENAGE VOLUNTEER PROGRAM APPLICATION

Please Check location you wish to volunteer at ☐ Port Charlotte ☐ Punta Gorda

PERSONAL INFORMATION

First _____ Middle _____ Last _____

Parent or Guardian name(s)_____Phone _____

Address _____E-mail _____

City _____ State _____ Zip _____

Phone _____ Cell Phone _____ Shirt Size _____

Date of birth _____ /_____ /_____ Age _____ Social Security No. __ __ __ – __ __ - __ __ __ __

Do you have any health conditions that may limit volunteer activity?
(Standing, walking, pushing, hearing, etc) yes ____ no ____ if yes, please specify: _____

EMERGENCY INFORMATION

Emergency Contact name _____

Relationship to you _____ Phone _____

QUESTIONNAIRE

Do you need confirmation of your hours for school? Yes [ ] No [ ] **Summer Start Date** _____
Why are you interested in volunteering? _____
Courses currently taking, school activities, clubs, honors, etc. _____
Are you seeking volunteer work as a requirement for any of the above activities/groups? Yes [ ] No [ ]
Have you ever volunteered in the past before (school, civic)? Yes [ ] No [ ]
Special interests/hobbies/skills: _____

- As a volunteer, I agree to abide by the policies and bylaws outlined in the volunteer handbook and set forth by the Hospital Board and the volunteer department of Bayfront Health Port Charlotte and Punta Gorda Hospital.
- I understand that I am volunteering at my own risk. Any injury that may occur needs to be reported to the Marketing Department and the Volunteer Services Department at the time of injury.
- If I am absent from my volunteer duties for 6 weeks or longer, I may have to be reassigned to another shift/service when I return.
- I understand I have 30 days from today to complete all mandatory health screenings/vaccinations as required by Employee Health Services and in order to volunteer.
- I agree to volunteer for a minimum of 60 hours to receive a confirmation of hours for school.
- My services are donated to Bayfront Health Port Charlotte and Punta Gorda Hospital without compensation or future employment and are given for humanitarian/charitable reasons. I will not receive any monetary gain nor be considered a hospital employee.
- I have never committed or been convicted of a felony.

Applicant's Signature: _____ Date: _____
Application submission opens January 1 and closes April 30. All applications must be submitted by the April 30 deadline. Acceptable candidates will be notified and scheduled for interviews starting in May for start dates in June.

Heather Rozelle | Marketing Manager | **Bayfront Health Port Charlotte and Punta Gorda**
809 E. Marion Avenue | Punta Gorda, FL 33950 | Tel: 941-637-2570 | PC: 941-766-4285 | Fax: 941-637-2567
www.bayfrontcharlotte.com

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AREAS FOR SERVICE

Please indicate your 1st, 2nd, 3rd, 4th, 5th and 6th choice in order of preference:

_____ **Lobby/Front Information Desk Service**: Teen volunteers will work with adult volunteers to provide wheelchair transport to patients and visitors who need assistance, escort visitors to destinations, and deliver mail and flowers to patients. Wheelchair training provided.

_____ **Nursing Services**: Teen Volunteers may transport patients by wheelchair, filing and restocking of supplies, and run errands for the Nursing staff. Departments may include emergency room, nursing floors, orthopedic, and ambulatory care. Wheelchair training provided.

_____ **Office Setting**: Filing and sorting papers, miscellaneous office duties and running errands. Departments may include human resources, education, wound care (includes computer work) and accounting.

_____ **Wellness Center and Rehab** (Punta Gorda only): Duties may include wiping down equipment, assisting staff, and other duties as assigned.

I am available the following times over the summer (circle only the actual days and time shifts you would like) **I need _____ hours for the summer**.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning	8a-12p	8a-12p	8a-12p	8a-12p	8a-12p	8a-12p	8a-12p
Afternoon	12p-4p	12p-4p	12p-4p	12p-4p	12p-4p	12p-4p	12p-4p

_____

Volunteer Name

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PARENTAL RELEASE

My son/daughter has my permission to participate in the Teenage Volunteer Program at Bayfront Health Port Charlotte and Punta Gorda Hospital. I understand that participation in this Program will involve a four hour weekly commitment of service.

If my son/daughter is unable to commit the above designated time commitment, I understand that he/she may be asked to leave the Program.

I understand that Teenage Volunteers are required to contribute a minimum of 60 hours of service whether they are participating for the purpose of High School community service hours or personal interest.

I understand that my son/daughter is responsible for obeying Hospital policies and procedures, and should a violation occur, they may be asked to leave the Program.

I understand that if my son/daughter is ill or cannot volunteer on the designated time period, he/she must call the volunteer office to report it.

If my son/daughter is injured in the course of their duties at Bayfront Health Port Charlotte and Punta Gorda Hospital, they are to report the injury to the Volunteer Services Department.

I understand that my son/daughter is volunteering their time without expectations of employment or monetary compensation.

I give permission for a drug test to be completed on my son/daughter for participation in this program and understand that I will be informed if the test is positive.

I further release the hospital from any legal or other responsibilities for any injuries, act, or incidents involving the volunteer.

_____ _____

Signature of Parent/Guardian Date

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CONFIDENTIALITY AGREEMENT

I recognize that the services provided by Bayfront Health Port Charlotte and Punta Gorda for its patients are private and confidential; that to enable the Hospital to perform those services, patients must furnish information to the Hospital with the understanding that it will be kept confidential and used only by authorized persons as necessary in providing these services; that the good will of the Hospital depends upon keeping services and information confidential; that certain legal obligations are attached to this information; and that by reason of my duties or in the course of my volunteer service I may receive or have access to verbal, written or electronic media information concerning patients and services performed by the Hospital even though I do not personally furnish the services performed for those patients.

I recognize that by reason of my duties or in the course of my volunteer work I may receive or have access to verbal, written or electronic media information concerning employees of Bayfront Health Port Charlotte and Punta Gorda and the facilities themselves.

I hereby agree, except as directed by the Hospital or by legal process, I will not at any time during or after my volunteer association with the Hospital, disclose any information whatsoever to any person or entity by any means.

In some agencies such as Hospitals, confidentiality is mandated by both state and federal law.

☐ I have read all of the above sections of this agreement, and I understand them.

Applicant Name:_____

Signature:_____

Parent/Legal Guardian Name: _____

Signature:_____

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