WE ARE EXCITED YOU ARE INTERESTED IN OUR STUDENT VOLUNTEER PROGRAM

2019 Student Volunteer Program

June 24th-August 23rd

THE OUTER BANKS HOSPITAL

the right care. right here.

Please complete the application by **April 1st** to be considered - NEW STUDENT ONLINE APPLICATION-CLICK HERE

This packet is for **NEW students only** - RETURNING students should complete the Returning Student Packet located on our website.

Thank you for your interest in our Student Volunteer Program, we believe this is a great opportunity for students to grow and develop professionally. We make every attempt to place student volunteers in their first department and schedule choice, however, this cannot be guaranteed. Please complete all applicable forms in this packet and return to the Volunteer Manager by mail or e-mail **no later than April 15th** (address below).

Commitment

The Student Volunteer Program will run from June 24th – August 23rd. During this time, volunteers are guaranteed one scheduled four hour shift per week. The program will run for nine weeks and we request that you are available for at least **seven of your nine shifts**. This is a big commitment and we request that you consider your schedule and availability prior accepting a volunteer position in this program.

Forms to complete

Objective and consent (Form 1 - return with packet)

User Agreement and Confidentiality Statement (Form 2 – return with packet)
This information is pertaining to patient and business confidentiality and requirements – we will discuss this information in more detail at orientation.

Criminal Record Check (Form 3 – return with packet if 16 years or older)

Occupational Health (Form 4 – return with packet if under 18 years old)
Please provide a copy of your immunization records with your packet. Required immunizations include; (2) MMR vaccines, (2) Varicella (Chicken Pox) vaccines, and (1) TDAP vaccine. Positive blood titers are acceptable for the MMR and Varicella. (3) Hepatitis vaccines are recommended, but not required. Documentation of a TB skin test if completed within the last year.

TB Screening

All returning and new volunteers are required to recieve their first TB test on one of the walk-in dates listed below. If you are under 18 years old a parent/guardian must accompany you to this appointment.
-Tuesday, April 30th, 4-5:30pm, Outer Banks Hospital Lobby (reading Thursday, May 2nd)
-Monday, May 6th, 4-5:30pm, Outer Banks Hospital Lobby (reading Wednesday, May 8th)
For **new** volunteers only: we require two TB skin tests, one must be provided by our Occupational Health nurse at a date listed above and the other must be completed within 7-21 days from a provider of your choice. We are offering a second TB screening on the following date:
-Tuesday, May 21st, 4-5:30pm, Outer Banks Hospital Lobby, (reading Thursday, May 23rd)

Orientation – Saturday, May 18th, 10am-12noon

All returning and new volunteers are required to attend orientation. Dress code is business casual, returning students can wear their volunteer uniform. Enter at the Main Entrance- we will meet in the lobby.

Return packet by e-mail or mail:
Kelly Divita
Kelly.divita@theobh.com
4800 S. Croatan Hwy
Nags Head, NC 27959

Form 1

Student Volunteer Program

New Student Form

Student Volunteer	
First Name	
Last Name	

Objective Statement:
Please write a brief objective statement regarding your interest in our Student Volunteer Program.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Parent/Guardian Consent

I, _____, give permission for _____
(Parent or Legal Guardian) (Student Volunteer)
to participate in The Outer Banks Hospital 2019 Student Volunteer Program.

Student volunteers are required to comply with all policies, procedures, and behavioral standards – failure to remain compliant can result in dismissal from the program. In addition, student volunteers should consider the programs level of commitment and dedication required. Letters of recommendation will only be provided to students in good standing at the end of the program.

Signature

Parent/Legal Guardian _____Date_____

Student Volunteer _____

Form 2

The Outer Banks Hospital

Vidant Health

User Agreement and Confidentiality Statement

I understand and will treat all patient information (i.e. medical, personal, social, financial and emotional) and the Outer Banks Hospital business information (collectively, "Confidential Information") acquired during the course of my work/affiliation as strictly confidential. I will only discuss Confidential Information in private and only with authorized individuals who have a medical and/or business-related need to know, whether on duty or off. I am legally responsible for my electronic and written signature and for the accuracy of the information I input into The Outer Banks Hospital medical or business records.

I will access Confidential Information only to the extent necessary to do my job. I understand that retrieving/viewing/printing or otherwise accessing information (electronic or paper), on patients (such as friends, relatives, neighbors, celebrities, co-workers, or myself) is a breach of confidentiality and can result in immediate termination and legal action against me.

I accept complete responsibility for my actions, and I understand that any violation of this Confidentiality Agreement may result in immediate revocation of my access to confidential information, removal from The Outer Banks Hospital premises, disciplinary action up to and including termination of employment, ability to provide services, and/or revocation of my ability to practice at The Outer Banks Hospital. (A member of the medical staff is subject to disciplinary action in accordance with Medical Staff Bylaws.)

My signature attests to the fact that I have read, understand and agree to abide by the terms if this confidentiality Agreement.

Date: _____

Signature: _____

The Outer Banks Hospital Employee

Name: (print) N/A

Employee #: N/A

Department: Volunteer Services

Work Phone: 252-449-4550

Non-The Outer Banks Hospital Employee

Name: (print) _____

Employer: Volunteer

Employer Address: TOBH Volunteer

Approved 7/13/98
Revised 10/22/2003, 9/1/2008, 2/8/2012

Form 3

Only complete if you are 16 years or older

DISCLOSURE/AUTHORIZATION STATEMENT

Vidant Health and its subsidiaries hereby disclose to you that a consumer report may be obtained for employment purposes as part of a pre-employment background investigation and at any time during your employment.

I understand that this document authorizes Vidant Health and its subsidiaries to procure a consumer report as part of a pre-employment investigation of my background. If hired, this authorization shall remain on file and shall serve as an ongoing authorization for any Vidant Health entity by which I am employed to procure consumer reports at any time during my employment period.

In connection with this request, I authorize all corporations, companies, former employers, supervisors, credit agencies, educational institutions, law enforcement agencies, city, state, county and federal courts, motor vehicle bureaus, military services, government agencies, and persons to release information that they may have about me to Vidant Health or any of its subsidiary, or any agent acting on behalf of Vidant Health or any of its subsidiaries. I hereby release all parties providing such information from any claims, liability, damages and responsibility for doing so.

This authorization, in original or copy form, shall be valid for pre-employment reports and any future reports or updates that may be requested.

I understand that I have the right to request additional disclosure as to the nature and scope of the investigation of my background upon written request to Vidant Health within a reasonable period of time from the date hereof.

I authorize the National Records Center, St. Louis, Missouri, or other custodian of my military records, to release to Vidant Health and its subsidiaries, or any agent acting on their behalf, information or photocopies of my military personnel and related medical records or only the following information/records:

_____	_____	_____
Applicant's Signature	Print Full Name	Date
_____	_____	
Name at Birth	Social Security Number	
_____	_____	_____
Date of Birth	Driver License Number	State

Military Service #:_____ Branch of Service_____ From_____To_____

Form 3

VIDANT HEALTH

Only complete if you are 16 years or older

Criminal Record Check Form

Background checks will be performed on every applicant hired at Vidant Health or its subsidiaries. If the information you furnish on this form is found to be false, you may be disqualified/dismissed, and you may not be considered for future employment/service for up to 18 months.

Please answer the following questions (Check all that apply):

1. **Have you <u>EVER</u> been:**
   a. Convicted of, or pled 'no contest' to, a misdemeanor other than a minor traffic violation? ❑Yes ❑No
   b. Convicted of, or pled 'no contest; to, any felony? ❑Yes ❑No
   c. Excluded from participating in any federal healthcare program by the OIG? ❑Yes ❑No
   d. Subject to having your professional license suspended, revoked, limited or placed on probationary or monitored status? ❑Yes ❑No

IF THE ANSWER TO ANY OF THE FOREGOING QUESTIONS IS 'YES', PLEASE EXPLAIN EACH CONVICTION ON THE NEXT PAGE, INCLUDING DATE, COUNTY AND STATE OR NATION OF CONVICTION. IF NEEDED, ADDITIONAL SHEETS ARE AVAILABLE UPON REQUEST.

2. Please list all names you have ever been known by, including any birth name, previous marital name(s), legally changed name(s), nickname(s) or alias(es).
   (1)_____ (2)_____
   (3)_____ (4)_____
3. Please list street, city and state where you have lived for the **<u>last ten (10) years</u>** including military and school addresses (use additional sheets if more space is needed)

_____	_____	_____
Street	Street	Street
_____	_____	_____
City County	City County	City County
_____	_____	_____
State Zip	State Zip	State Zip
Dates: From_____To_____	Dates From_____To_____	Dates From_____To_____

I hereby certify that the answers on this application and any addendum are true and correct, and that any misrepresentation or false information on my part may disqualify me as a candidate for employment/service, or if employed, will be grounds for discipline up to and including termination. In connection with this request, I authorize all law enforcement agencies, city, state, county, and federal courts to release information they may have about me to Vidant Health and its subsidiaries, or any agent acting on their behalf.

_____	_____	_____
Signature of Applicant	Print Full Name	Date
_____	_____	_____
Date of Birth*	Social Security Number	Valid Driver's License #
_____		_____
Current Address City State Zip		State where license was issue
Dates From_____ To_____		

* Date of Birth is required solely for purpose of conducting a criminal record check and will not be used for any other reason in the employment/service or application process.

Form 3

Only complete if you are 16 years or older

VIDANT HEALTH™

Please use this sheet to explain your conviction(s)

Date of conviction:_____
County & State of conviction:_____
Crime for which you were convicted:_____
_____
Explain: (Optional)

Date of conviction:_____

County & State of conviction:_____
Crime for which you were convicted:_____
_____
Explain: (Optional)

Date of conviction:_____

County & State of conviction:_____
Crime for which you were convicted:_____
_____
Explain: (Optional)

Form 4

CONFIDENTIAL RECORD
Vidant Occupational Health
Demographic Information Sheet for Volunteers

Name: _____
Last First Middle

Date of Birth: _____/_____/_____ **Social Security #** _____

Address: _____
Street/Apartment/P.O. Box

_____ _____ _____
City State Zip

Contact Phone #: (_____) _____-_____

_____ _____
Personal Physician's Name and Address Phone #

_____ _____ _____
Name of Emergency Contact Relationship To You Phone #

Allergies: (Food, Medication, Latex, Etc.) _____

Current Medications: _____

ACKNOWLEDGEMENT OF INSTRUCTION REGARDING ACCIDENTAL INJURY
If you sustain an injury while on duty at Vidant Health, please seek care as needed and contact Vidant Risk Management.

ACKNOWLEDGMENT OF INSTRUCTION REGARDING BLOOD EXPOSURES
All blood exposures are to be **immediately** reported to the Manager/Supervisor/Charge Person **and** Vidant Occupational Health Department where the volunteer will be instructed on the process. If Occupational Health is closed, the Manager/Supervisor/Charge Person will contact the Patient Care Coordinator/Nursing Supervisor **immediately**. The Patient Care Coordinator/Nursing Supervisor will instruct the volunteer on the process.

I have read the above information, and have had an opportunity to ask questions which have been answered. I understand that it is my responsibility to contact Vidant Occupational Health at any time I have a job-related exposure to any communicable disease.

_____ _____
Signature of Volunteer (or parent/guardian if under 18) **Date Signed**

Form 4

Vidant Occupational Health Clinic

VIDANT HEALTH™

VIDANT MEDICAL CENTER AUTHORIZATION FOR TREATMENT OF MINORS

Hospital Infection Control policy requires documentation of immunization for measles, mumps, rubella, varicella, and tetanus/diphtheria/pertussis, as well as tuberculin skin testing. If adequate documentation is not provided, immunizations and/or lab testing will be required for your child.

Drug screening may be a part of the pre-employment process. It may also be done during employment if there is "reasonable cause."

I, the undersigned parent/guardian of _____, a minor, authorize Vidant Occupational Health Clinic, through its physicians or nurses, to perform required medical screening, drug screening, and/or immunizations in order to comply with hospital policy for employees and volunteers of Vidant Medical Center as outlined above.

Should my child need to be treated for minor illnesses and/or work-related injuries while employed or volunteering at Vidant Medical Center, I give permission for treatment to be administered by the physicians or nurses of Vidant Occupational Health Clinic or the Vidant Emergency Department.

I understand that my authorization lasts until I take back my authorization, which must be done in writing.

_____ _____

Parent or Legal Guardian Witness Signature

_____ _____

Minor Witness Name (Please Print)

_____ _____

Minor's Social Security Number Date

*****RETURN THIS COMPLETED FORM AND IMMUNIZATION RECORDS IF AVAILABLE BY THE END OF YOUR SCHEDULED INTERVIEW/APPOINTMENT****